Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 08001 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 4:20 PM FEBRUARY 21 2009 DOROTHY HUBBARD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MANOR CARE SILVER SPRING MONTGOMERY SILVER SPRING 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗓 F Director 061-16-5356 JUNE 3, 1915 DC Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28a-f show d other than "natural", or items 23a or 28a-f show event, the Woolcal Experience must be motified at 1 X Yes 2 No Director SILVER SPRING MD MONTGOMERY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 2501 MUSGROVE ROAD 20904 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 □Yes 2 No <u>ک</u> Specify. 3 X Widowed 4 □ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) US STATE DEPARTMENT SECRETARY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last Be ELIZABETH GRIMES FRANK JOHNSON ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 si Department of Health an Important: If Item 27 is 1 any injury or other trau 20011 YVONNE C. REID / NIECE 230 ONEIDA STREET, NW WASHINGTON, DC 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 □ Donation HARMONY MEMORIAL PARK: 02-27-2009 LANDOVER, MD 21. Signatur of Funera Service Licensee 22. Name and Address of Facility MARSHALL'S FUNERAL HOME, INC. 4217 9TH STREET, NW WASHINGTON, DC 20011 Approximate Interval Between Onset and Death 23a. Part i Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Gangrene /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Peripheral Vascular Disease Examine Due to (or as a consequence of) certificate be executed and burial-trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) □Yes 2XNo signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. **☆**□ Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed Hypertension, Dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 M Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year) 32. Registre

FABIENNE SANTEL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2094



GAITHER ROAD

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Records,

of Vital

Division

00061768

ROCKVILLE, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-01373 State of Maryland / Department of Health and Mental Hygiene Jason Harper <u> 2009 080</u>02 Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day February 16, 2009 1043 hrs Medical Examiner Bruce Harper Jason c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Months Hours Days DEC. 6, Country) Kansas 1960 Director 48 1 X M 2 F 515-76-4268 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County any 10a State 1 X Yes 2 No 28a-f show Germantown "natural", or items 23a or 28a-f shov Examiner must be notified at once. Maryland Montgomery more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe United States of Amerida 喜 20876 12203 Stardrift Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? Never Married 2 X Married 2X No Yes If Yes, Give Year Yes 2 X No specify: Specify: African American Widowed Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) event, the Medical marked other than Law Tax Attorney 5+ and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last <u>Helen Patricia Faulkner</u> Be <u>Winford Harper Sr.</u> (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ant of Health and M nt; If item 27 is m: 12203 Stardrift Drive; Germantown, MD 20876 <u> Morton - Wife</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 XCremation 3 Removal from State permit. Page Department o tant: 02/27/09 Brentwood, Maryland Lincoln Crematory Donation 5 Other Specify 22. Name and Address of Facility Simple Tribute Funeral & Cremation Import vice Licensee 21. Signature of Funeral Se 1040 Rockville Pike; Rockville, MD 20852 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Medical Death a. Pulmonary Thromboembolism complicating leg fracture Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last death certificate be executed and trans hysician/Medical ing physician a UNPENDED AMENDED 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Ö No 3 Probably 4 ✓ Unknown Yes 2 ⋧ Completed Records, 24b. Were autopsy findings available 24a. Was an autopsy pnor to completion of cause of performed? this certificate has I director, page 2 sl death? The law 1 1 ✓ Yes 2 No Yes 26 Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical of Vital Be Hospital: 1 Other₄ examiner? Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 🗸 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury 28b. Time of Injury Manner of Death Subject fell Certification: Jan 25, 2009 Division 0515 hrs Yes 2 ✔ No Pending the Director: 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City in by Could not be Suicide or Town, State) 12203 Star Drift Drive, Germantown, MD determined (Specify) Single Family Home Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

Registra

Ana Rubio MD.

31. Date filed (Month Pay)

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

2009

Assistant Medical Examiner

February 17, 2009

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Amend 20b, perFH 2891, 5/14/09 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Bruce Albert Heller February 2009 6:15 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Collegeview Nursing Home Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min. 578- 36-9604 78 Feb. Washington, D¢ Director 4, 1931 Usual Residence of Decedent with the Maryland 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Wedical Examinant", ust be notified at Director 1 ☐ Yes 2 KNo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5610-B Avonshire Place 21703 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: Korea 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No \$ Specify. Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the Magnes. Elementary/Secondary (0-12) College (1-4or 5+) Manager Automotive Retailer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Heller, Jr. Elizabeth Hannah Arnold ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edythe Lorraine Heller/Wife 5610-B Avonshire Place, Frederick, MD 21701 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State March 2, Arlington National Arlington, Virginia 4 Donation 5 Dother (Specify) 2009 Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** robable disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if a y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed burial-transi Due to (or as a consequence of): attending physician for use as the burial Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an icate has page 2 s The 3 certificate Vital 1 ☐Yes 2 ☐ No 1 ☐ Yes 2ENo Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ № 6 After this funeral dir Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Division of 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C filled PC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shah temen lhoma Tohnson 31. Date filed (Month, Day, Year) State **FEB 27** Registrar

		1 - State Amended #31 -	State of Ma 32 Per F	ryland / De CHD <i>C</i>	partment of ertificate of	Health a Death	nd Mental Hy 03/02/200	Reg. No.	9	08004
Physic	ian	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Year	3. Time of Death 7:40 PM
/Medi		Shirley Ann Heath 4a. Facility Name (If not institution, give stre	net and number)		4b. City, Town,	or Location of	Death 2	4c. County	009	7:40 P ^M
Exami	ier	2141 Reed Rd.	,		Knoxvi				shing	ton
Funeral Director		5. Social Security Number 6. Sex $220-34-0687$	7. Age	(In yrs. last birthda 9 Yrs	Months Dave		4 Hrs. 8. Date of Bit (Month, Date 11/2.	3/1939		ace (State or Foreign ry) Wick MD
land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10	Od. Inside City Limits
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with the 3e or 28e	i Director	10e. Street and Number 2141 Reed Rd.			10f. Zip Code	758		10g. Citizen of	What Count	try?
portinition (s), Marylania 412.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23e or 28e-f show may injury or other treumatic event, the Medical Examinat must be notitled at once.	by Funeral	11. Marital Status 12. 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Was Decedent Ev Armed Forces? 1 Yes 27 No If Yes, Give Year or Dates:		3. Was Decedent of If Yes, specify Cu	ban, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	3- 14. Rad Bla Specifi	ce - America ck, White, e	etc.
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NIGITY nd 2 shou tith and h 27 is mai		19a. Informant's Name/Relationship (Type, Teresa Miller, Daug					or Rural Route Numb 7, Brunswi		State, Zip	Code)
S 1 au S Hea other		20a. Method of Disposition		20b. Place of Dis	sposition (Name of crematory or other pl	ace)	Date	20c. Location	City or Tox	wn, State
Page Page nent c		1 ☐ Burial 2√☐ Cremation 3 ☐ Rem '4 ☐ Donation 5 ☐ Other (Specify)	loval from State	1	n Cremetory		/2/2009	Hagerst	own M	1D
Defiling permit. Pages Department of Importent: If it eny injury or one.		21. Signature of Fuleral Services Licensee Barbara A Willia	ams		22. Name and Add		eral Hore, B	runswick N	D 2171	6
		23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one	tions that caused to	he death. Do not	enter the mode of dy	ring, such as c	ardiac or respiratory a	rrest,		Approximate Interval Between
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/Medical Examiner		resulting in death)	Due to (or as a	consequence of):						1-
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icate be executed physician and the burial-transit	dicai	d								
To the Hospitel or Attending Physicien: The law requires that the death certification at the fours after death. To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 D No 9 □ Unknown	If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death	3 □Ectopic pregnan 5 □ Other (specify)	су		A 1	te of deliver	y Day Year
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tending P leath. lor: After t	ation:	2 Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time Injur	y W	uryat ork?]Yes 2∐N		how injury occur	red	
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TVISION To the Hospitel or Attending Within 24 hours after death. To the Funerel Director: After Completely filled in by the fune	edical (29a. Certifier 1 A Certifying Physici (Check only one) 2 Medical Examiner	ien: To the best of : On the basis of e and manner state	xamination and/or	eath occurred at the investigation, in my	time, date and opinion, death	place, and due to the occurred at the time,	cause(s) and ma date and place,	anner as sta and due to	ited. the cause(s)
Vithii To the	X	29b. Signature and title of certifier)		29c. Licer	se number		29d. Date signe	d (Month, D	Day, Year)
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U		30. Name and address of person who comp	(i MD)	ath (Item 23a) (Type 80 / Sectionature #	Tou	House	e Ave,	Freder	icle	MD 21701
Sta Regist		31. Date filed (Month Day Mear) 19 20	09 Sever	un B.	1 garkal					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year SAMUEL KAVRUCK 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death HOME ZOCKVILLE MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 1 ▲ M 2 ☐ F Months Days Hours Yrs. 007-05-3942 94 January 20, 1915 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1x Yes 2 □ No DC Washington 10e. Street and Number 10g. Citizen of What Country? 5712 26th Street. 20015 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ★Yes 2 □ No If Yes, Give Ye ar or Dates: ₩WII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify Specify. 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Psychologist 5+ U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Meyer Kavruck Sophie Gutman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26th Street, NW, Washington, DC 20015 Deborah Kavruck - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Lebanon Cemetery 02/26/2009 Adelphi, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 First 1. Enser the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cruse (Final MYLICATIONS disease or condition resulting in death) 2470MIHS Due to (or as a consequence of) Sequentially list conditions, it any, bound to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence off resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner Examine physician and s the burial-transit P.O. Box 68760. Physician/Medical

Physician

/Medical

Examiner

Director

Funeral

2

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Mailcal Exp. inter traus be refilled at once.

Baltimore, Maryland 21215-0036

attending physical for use as the t After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be Certification: To Director:

Completed by

Medical

completely 10+1

Division of Vital Records,

ATRIAL FI	BRILLATION	24a. Was an autopsy performed? 1 □ Yes 2 □ No
25. Was case referred to medical	26. Place of Dea	ath (Check only one)
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	lame 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work? on M 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not determine		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of my knowledge, death occurred at the time, date and place aminer: On the basis of examination and/or investigation, in my opinion, death occur	e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of per on who completed cause of death (Item 23a) (Type, Print)

and manner stated.

BRIMMER HLLEN M.D. MONTROSE ROAD. ROCKULLE, MARYLAND 6121

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and hit

			Please 7	Type or Prin	nt in B	lack In	delible Ink.	Ensure A	II Copies	Are Leg	jible.	
		For		State of Ma	aryland	d / Depa	artment of H	lealth and M	Mental Hyg	giene		
		1 - State Registrar				Cei	rtificate of L	Death	F	Reg. No. 2	09	08006
Physici	an	1. Decedent's Name (Fin	First, Middle, Last	t)					2. Date of Dea Month	Day	Year	3. Time of Death
/Medi		Anna E.							Februar		2009	3 = AM
Examir	ier	4a. Facility Name (If not		Nursing C	om+om		4b. City, Town, or Emmitsb	Location of Death			ty of Death deric	
Funeral		5. Social Security Numb				ast birthday)	If Under 1 Year		8. Date of Birtl	h	9. Birth	nplace (State or Foreign
Director		212-40-487	4.0	JM 2X7E	66	Yrs.	Months Days	Hours Min.	(Month, Day	v. Year)	Cot	nintry) 1and
pt ,		Usual Residence of Dec	cedent		1.0 00							
arylar show dat	<u>_</u>	10a. State 10b	b. County		10c. City	, Town or Lo						10d. Inside City Limits 1 XYes 2 No
the M 28a-f otifie	Director	Maryland 10e. Street and Number	Worce	ster		0ce	an City			10g. Citizen o	5 14 ft - 4 O -	
with ya or the n				ghway, Un	i+ 30	<u>.</u>	10f. Zip Code	842		United		*
reath ms 23 mus	Funeral	11. Marital Status	istal III	12. Was Decedent			Was Decedent of Hi If Yes, specify Cuba					ican Indian,
after or iter	표	1 ☐ Never Married	2 X Married	Armed Forces? 1 ☐ Yes 2 📉	No				Rićan, etc.)		ack, White	
ours a	d by	3 ☐ Widowed 4 ☐	Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 📉 No	Specify:		Spec	ify: V	Thite
72 h "natu	ete	15. (Specify o	. Decedent's Edu only highest grad	ucation de co <i>mpleted)</i>		16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of work	king	16b. Kind of	Business/I	ndustry
within ene. than	Completed	Elementary/Secondar	ary (0-12)	College (1-4or 5	5+)		eteria Ma			Food	Tadue	. +
filed Hygid	ပို	17. Father's Name (First	st, Middle, Last)	Τ1		Car	eteria Ma	18. Mother's Name	e (First, Middle,	Food Maiden Surna		stry
lid be lental ked c	To Be	Norman Wi	ilder					Dolores	s Folder	auer		
shou s mar		19a. Informant's Name/					ng Address (Street a					
and 2 ealth n 27 i		Milton Kow	valewski 	/ Husban	d	7604	Coastal	Hwy, Unit	3G, Oc	ean Ci	ty, M	ID 21842
ges 1 t of H if Iter or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cr		Removal from State	20b. Pl	ace of Dispo emetery, crei	osition (Name of matory or other plac	(e)	Date	20c. Location	- City or	Town, State
t. Partmen		4 Donation 5 □			A1		1s Cemete					, Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Department of Health and Mential Hygiene. Inmoortant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funera	al Service Licens	see		22	2. Name and Addres	ss of Facility S	Stauffer			
		23a. Rant1. Enter the di shock, or heart fail	disease for comp	lications that cause	the death	. Do not ent					ıck,	
Physician		Immediate Cause (Final		one cause on each li	ne.		0 1/		-	1000		Approximate Interval Between Onset and Death
/Medical		disease or condition resulting in death)		a. Due to (or as	a consequ	ience/of):	- me	10310	110			
Examiner		Constant list on dist	[h		Dua	rean	Ca	NCE			3 YRS
το #	iner	Sequentially list condition if any, leading to immed cause. Enter Underlying Cause (Disease or injury)	ions, ediate	Due to (or as	a consequ	ience of):						
executed in and ial-transi	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	ITY T	c Due to (or as								
be jcia		,,		Due to (or as	a consequ	elice or).						
The law requires that the death certificate tee has been signed by the attending physioage 2 should be detached for use as the I	Physician/Medical		•	d								
n certi nding use a	n/M	IF FEMALE: 23b. Was decedent pre-	eonant	23c. If yes, outcome						23d. E	ate of deli	verv
death e atte	icia	in the past 12 mon 1 ☐ Yes 2 ☐ No	nths?	1 ☐ Live birth 4 ☐ Pregnant at			⊒Ectopic pregnancy ⊒ Other <i>(sp</i> ec <i>ify)</i>				N onth	Day Year
at the by th	hys	9 ☐ Unknown		9□Unknown					<u> </u>			-
res tha iigned be dei		Part II. Other significan	nt conditions co	ontributing to death b	ut not resu	Iting in the u	nderlying cause give					the cause of death?
law requires as been signe	Completed by	0142100	0439	100/10	- J.)100	01 113	earl	1 D Y	es 20 No	3 □ Pro	obably 4 □Unknown
has the second	mple	4051 W	rult	fle 1	114-	e (00	na		24a. Was autop	ISV J	prior to c death?	topsy findings available ompletion of cause of
n: Th ficate or, pag		Sei 70 25. Was case referred to	are	paor	de	1			1□ Yes	2 2 No	1 Yes	2 No
/sicia	o Be	examiner?	/	Hospital: 1 ☐ Inpatie	ent 2 🗆 8	ER/Outpatier	nt 3 DOA Othe	er: 457 Place of Deat	th <i>(Check only o</i> ome 5□Resid		H (O	
g Phyter thi	n: To	27. Manner of Death		28a. Date of Inju	ry	28b. Time o			28d. Describe h			ary)
endin ath. or: Af he fur	atio	2 Accident	Pending investigation	(MOIIII, Da	y rear)	injury		Yes 2□No				
or Att ter de lirect	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Place of injuding, et			reet, factory, office		28f. Location (S City or Tow	Street and Nur. vn, State)	nber or Ru	ral Route Number,
pital ours all		00- Cadifica 4 🗆	Walterian Dh.		of my language		h					
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific: completely filled in by the funeral director,	Medical	29a. Certifier 1 - (Check only 2 - one)	Medical Exam	vsician: To the best niner: On the basis o and manner sta	f examinat	ion and/or in	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	red at the time,	cause(s) and i date and plac	nanner as e, and due	to the cause(s)
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Me	29b. Signature and title	e of certifier				29c. License	e number		29d. Date sigr	ed (Month	, Day, Year)
		Bons	ta TK	roun Pa	el-4-	2712	100 He	2440	33	02-2	4-	2009
(1,2)		30 Name and address	of person who c	completed cause of d	eath (Item	23a) (Type,	Print)	121-12	3 W	23766	19 4	STREEL.
		31. Date filed (Month, D	Day Year)	2 TUN PE 32. Hegistr	ar's Signat	KRT	IER PO	Eum	1.156	ans a	ui	(595)
Sta	ite	or. Date liled (NORU), D	1 P 1 2 2	Ang Sz. Registr	ar o oigiidi	h	6-11		*	-		/

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ONK ONK	1- For State Certificate of Department of F			I. No. 200	0 0000
Physician/ Medical Examiner	Decedent's Name (First, Middle, Last)	1 81	2. Date of Death Month	Dav Year	3. Time of Death
medical Examine	EVA LILES KINSEI	City, Town, or Location of Dea	March 6, 20	4c. County of Deat	0341 hrs
		Cheverly		Prince Georg	
Funeral Director		If Under 1 Year If Under 24Hi Months Days Hours Mi		(MM/DD/YYYY) 9. Bi	thplace (State or Foreig
	237-72-8491 1 M 2 XF 65 Yrs.		AUG 25	, 1943	NORTH CAROLINA
w any	10a. State 10b. County 10c. City, Town or Location		· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits
Maryland 28a-f show 1 at once ector	MD PRINCE GEORGE'S LANDOVER 10e. Street and Number	Of. Zip Code	140	g. Citizen of What Cou	1 X Yes 2 No
rith the Maryland 23a or 28a-f show notified at once al Director	7224 FLATSTAFF STREET	20785	100	USA	nuy?
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified it diece ed by Funeral Director	11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was D	ecedent of Hispanic Origin? (S specify Cuban, Mexican, Puert			ican Indian, Black,
or its	1 Yes 2 X No	es 2 X No specify:	o Rican, etc.)		A CIZ
ours aff	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's I	Usual Occupation (Give kind of		Specify: BL. 16b. Kind of Business/	
36 in 72 h han "n lical E	Elementary/Secondary (0-12) College (1-4 or 5+)	of working life. DO NOT use re IAN/BARBER	tired).	PRIVATE	
5-0036 ed within 72 hour stygiene. the Medical Exam Completed	17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma		· · · · · · · · · · · · · · · · · · ·
1218 Tbe file ental H rirked vent, tl	CLAYTON LILES	ELMA	ROBINSON	,	
Baltimore, MD 21215-0036 permit. Pages I and 2 shou d be filed within 72 hours after death will Department of Health and N ental Hygiene. Implyant: If item 27 is nurrised other than "natural", or items injury by other traumatic event, the Medical Examiner must be To Be Completed by Funera		ddress (Street and Number or SHELTON STREET			
e, N 1 and 2 Health litera 2	20a. Method of Disposition 20b. Place of Disposition	n (Name of cemetery,		20c. Location - City or	
Pages Pages nent of ant: II	1 X Burial 2 Cremation 3 Removal from State crematory or other 4 Donation 5 Other Specify RESURRECTION		12/2000	CLINTON	MARYLAND
Balti Permit Pepart Mport Injury	21. Signature of Funeral Service Literasee 22. Nam	CEMETERY 3/e and Address of Facility J.	B. JENKI	NS FUNERAL	HOME
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the many complex to the death.	74 LANDOVER RO			ID 20785 Approximate Interva
/Medical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease a. <u>Smoke inhalation and</u>				Between Onset and Death
Canine	or condition resulting in death) Due to (or as a consequence of):				
ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	- 15 E-361E			
ramine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			-	
and and all Ex	d	MF ~000 2/21	700 mm		
'60, cate be exect physician an the burial - tr		me, gooy 3/31	/09 11		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transe edical Certification: To Be Completed by Physician/Medical E.	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal of	death 3 Ectopic pregn	ancy	23d. Date of deliver Month	V Day Year
Box 687 c death certific the attending of for use as the artending of the	. Program at time of death	(Specify)			
P.O. Bost that the degree by the edutached for by Physical By Physical By Physical P	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
S, P.C puires that an signed ld be dete ed by				2 ✔ No 3 Prol	
Division of Vital Records, rat or Attending Physician: The law requirents after death. "In Director: After this certificate has been signed in by the funeral director, page 2 should be ertification: To Be Completed			24a. Was an autopsy perform	prior to	topsy findings available completion of cause of
Vital Rec sysician: The h this certificate h director, page	25. Was case referred to medical		1 ✓ Yes 2		es 2 No
Vital ysician this cert directo	examiner? 1 Vers 2 No Hospital: 1 Inpatient 2 VER/Outpatient 3	26.Place of Death (Check		esidence 6 Othe	
of Vi ing Physi After this uneral dir	27. Manner of Death 28a. Date of Injury 28b. Time of Injury (Month Day Year)		28d. Describe ho	w injury occurred	
Sion Attend death ector: by the f	Pending Investigation Fd 3/6/09 Fd 3:00			of house f	
Division o spital or Attending hours after death. neral Director: After filled in by the fune Certification:	3 Suicide 6 Could not be determined (Specify) 128e. Place of Injury - At home, farm, street, far house	actory, office building, etc.	28f. Location (Str or Town, Sta	reet and Number or Rute) 7224 Flag	ral Route Number, City sstaff St
Division of Nother Hospital or Attending Physikin 24 hours after death. To the Funeral Director: After to the Funeral Director: After to the funeral Director: After the funeral Certification: T	4 Homicide (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred	at the time, date and place, an			
To the IIs within 24 To the Fu complete!	one) 2 Medical Examiner:On the basis of examination and/or investigation, and manner stated.				
/ \$	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo.	nth, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		March 6, 2009	
21	Ana Rubio MD. Assistant Medical Examiner 111 Penn Stre	et, Baltimore, MD 2120	1		
State	31. Date filed (Manth, Day, Year) 2009 Lane S. Sauce	,		-	
Registrar	THE PARTY OF THE P				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Depar			ental Hyg	giene	
			- riegional	ificate of L	Death		leg. No. 2 0 0 5	08008
	Physici:	_	1. Decedent's Name (First, Middle, Last) Lawrence Bernard Luzenski			2. Date of Dea Month Februa	Day Year	3. Time of Death 3:32 a ^M
1	Examin		,,		Location of Death		4c. County of Dea	ith
	Can have traffered the		Washington Adventist Hospital	Takoma				gomery
Ľ	Funeral Director			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Dec. 2	(, Year)	thplace (State or Foreign ountry) nnsylvania
	pur 🔪		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loca	ation				10d. Inside City Limits
	Maryla a-f shov ifled at	ctor	Maryland Prince George's Adel					1 ☐ Yes 2 No
	with the	Director	10e. Street and Number 2704 Rambler Court	10f. Zip Code 20783			10g. Citizen of What C	ountry?
	ms 2: mus	Funeral			ispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No-		
39	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fur	1 □ Never Married 2 📉 Married 1 💢 Yes 2 🗍 No	Yes, specify Cuba ⊒Yes 2. Taxt No	Specify:	Hican, etc.)		te, etc. hite
21215-0036	72 hou 'natura	Completed	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give kij	nt's Usual Occup	ation during most of workir t)	ng I	16b. Kind of Business	/Industry
121	within ene. than "	dmc	Elementary/Secondary (0-12) College (1-4or 5+) 5+	Teacher	•	:	Educatio	n
	other rent, tl	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle,		
ylan	should be trud Mental I	To B	William Luzenski			a Gawar		
Maryland	s 1 and 2 should of Health and Mer Item 27 is marke other traumatic						r, City or Town, State, hi, MD 207	'
Baltimore,			1 Burial 2 Ki Cremation 3 Li Hemoval from State 1	atory or other plac	e) Fel	ate b. 26.	20c. Location - City o	
Itim	t. Parturant		4 □Donation 5 □Other (Specify) Metropolit 21. Signature of Funeral Service Licenses 22.		atory 20	209		a, Virginia
Ba	Depar Impor any Ir						1 Home Inc Silver Spr	
5			23a. Part1. Enter the disease, o complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	the mode of dyin	g, such as cardiac o	r respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a. Pneumon 1					Onset and Death
	/Medical Examiner		Due to (or as a consequence of):					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Indexing.					
)	ecutec and -transi	Examine	cause. Enter Underlying Cause Disease or houry that initiated events resulting in death) Last C					
68760,	icate be executed physician and s the burial-transit	calE	d					
		/ledical	UE FEMALE.					
Вох	leath certific attending p	ian/N		ectopic pregnancy	/		23d. Date of de Month	elivery Day Year
o.	The law requires that the death certi tte has been signed by the attending page 2 should be detached for use a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ 0	Other (specify)				,
Δ.	res that igned b be deta	by Pl	Part II. Other significant conditions contributing to death but not resulting in the und Atrial Fibrillation	lerlying cause give	en in Part I.		bacco use contribute	
ord	w require been si should t	ted	Actial Fibrillation			1 D Y	′es 2 No 3 F	Probably 4 MUnknown
Vital Records,	The law ate has b page 2 sl	Completed				24a. Was a autop perfor	sy prior to rmed? death?	
tal		a	25. Was case referred to medical		26. Place of Death	1 Yes (Check only o	74	s 2 No
r N	nysic lis ce direc	To B	examiner? 1 Yes 25 No Hospital: 1 Inhapatient 2 ER/Outpatient	3 DOA Oth	or:		lence 6 □Other (Sp.	ecify)
n or	ling After une		27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury 28b. Time of Injury	28c. Injur Worl		28d. Describe h	ow injury occurred	
Division	il or Attending after death. Director: After d in by the fune	ficat	2 Accident Investigation 3 Suicide 6 Could not be determined determined		Yes 2 □No 2	28f. Location (S	Street and Number or F	Bural Route Number,
Ö	- e = -	Certification:	4 Homicide determined building, etc. (Specify)			City or Tow	n, State)	
	To the Hospital or within 24 hours after to the Funeral Director Completely filled in the formulate of the f	ledical (29a. Certifier (Check only one) **CertifyIng Physician: To the best of my knowledge, death of the basis of examination and/or investigation and manner stated.					
	To the Hos within 24 hd To the Fun completely	Me	29b. Signature and title of partities	29c. License			29d. Date signed (Mon	
F,	107		· /VYWAIL	-	D45471		February 2	5, 2009
(10)		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr Yeheyis Negussie, MD 7600 Carroll		Takoma Pa	rk, MD	20912	
Ţ	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature	4.1				

		mend #8 P		State	OI WIATY	Ce	rtifica	te of L	Death	and W	ена Н	ygien Reg. N		09 08	100
 :-:		Decedent's Nan	ne (First, Middl	e, Last)							2. Date of D	eath		3. Time	of Death
hysici /Medi		4a. Facility Name	If met inntitution			MC	_	Hise			MARC	H .	5 20	02 185	2
xamiı	ner	The Johns			iumber)			y, Town, or t imore		of Death		4	c. County o		
neral		Social Security I		6. Sex	7. Age (In	yrs. last birthday,	If Und	ler 1 Year	If Unde	er 24 Hrs.	8. Date of B	lirth		imore 9. Birthplace (State	or Forei
ctor		246-94-		1 🗆 M 2 📈 F	52	Yrs.	Months	s Days	Hours	Min.	May 2	0,19	56 _[Country) Vinslow, A	Z_{-}
		Usual Residence of 10a. State	f Decedent 10b. County		100	c. City, Town or L	ocation		-		_			10d. Inside	
	cto	PA	Nor	thampton		Bath, E	PA							¥E Ye	es 2 🗆 I
outer traumatic event, the medical examiner must be notified at	Dire	10e. Street and Nu		_				ip-Code				10g. C	itizen of Wh	nat Country?	
	era	124 Che	estnut			Tio Tio		18014					Amer:		
	Funeral Director	11. Marital Status 1 ☐ Never Marı	ied 2 ∏ Marr	Armed	ecedent Ever i Forces? s 2 TNo Give	n U.S. 13.			ispanic Oi in, Mexica	rigin? (Spe ın, Puerto F	cify Yes or N lican, etc.)	0-		- American Indian, White, etc.	
	d by	3 🗌 Widowed	4 ☐ Divorced	If Yes, 9 Year or	Give A Dates:		1 🗌 Yes	2 X No	Specify	<i>r</i> :			Specify:	White	
	Completed	(Spe		t's Education st grade complete	d)	(Give	kind of v	sual Occup vork done d	during mo	st of workin	ng	16b.	Kind of Bus	siness/Industry	
	d E	Elementary/Sec	ondary (0-12)	College	(1-4 or 5+)			use retired)				D		
	Be C	17. Father's Name		,		wai	tres	S	18. Moth	ner's Name	(First, Midd		Restra en Surname		
	10 B	Raymono	l Simmo	ns					В	etty	0xend:	ine			
		19a. Informant's N				1								tate, Zip Code)	
		Billy (20a. Method of Dis		Ţ	Tac						h Rd.				91
			Cremation	3 Removal from		Ob. Place of Disp cemetery, cre					ate	Į.		ity or Town, State	
once.		21. Signature of Fu		**		Cape Fea		emato and Addres						NC 2839	1
OUC		James	E to	inell 4	/ FSL-	-2053 B	ut le	r Fun	eral	Home	653 St	35 C.	lintor	n Rd. C. 28391	
n II		23a. P vt . Enter t sh k, or hea Immediate Cause (disease or condition resulting in death)	rt failure. List o Final	a.	each line.	sequence of):	ter the me	ode of dyin	g, such as	s cardiac o	r respiratory	arrest,		Approxima Interval Be Onset and	etween
er	ner	Sequentially list co if any, leading to in cause. Enter Under	nditions,	b	o (or as a con										
1	Examiner	that initiated events resulting in death)	injury	c	o (or as a con	sequence of:									
nor use as the burial-transit				d						, <u> </u>					
	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 9 ☐ Unknown		1 Liv	outcome of pre e birth 2 time gnant at time known	Fetal death 3	☐ Ectopic ☐ Other (s	pregnancy specify)	,				23d. Date of Month		Year
	by P	Part II. Other signif	icant condition	ns contributing to	death but not	resulting in the	underlying	g cause giv	en in Part	t I.	23e. Did	tobacco	use contrib	oute to the cause of	death?
	ted										1 🗆	Yes 2	2 No 3	Probably 4	Unknow
	Completed										24a. Was	veg	l pri	ere autopsy findings or to completion of	availab cause c
		25. Was case refer	ad to madical									ormed? 2 N	0 1	ath? ☐ Yes 2 ☐ No	
	m	examiner?		Hospital: N	Innation 1	ER/Outpatier	+ 2 D	Othe	r.		Check only		0 0 0 0 1	<i>(</i> 2	
1	은 ::	27. Manner of Deat	h	28a. Dat	e of Injury	28b. Time o		28c. Injury	at		e 5 🗆 Res 3d. Describe				
	atio	1 Natural 2 Accident	5 Pending investig	ation	inth, Day Year)	Injury	М	Work'	? ′es 2 🗌	No					
	Certification:	3 Suicide 4 Homicide	6 Could r determi	nod Zoe. Flat	ce of injury - A ding, etc. (Spe	t home, farm, str ec <i>ify)</i>	eet, facto	ry, office		21	3f. Location City or To			or Rural Route Nur	nber,
		29a. Certifier	1 Certifyin	g Physician: To the Examiner: On the and ma	e best of my label basis of exame anner stated.	knowledge, death ination and/or in	occurred vestigatio	d at the tim	e, date ar pinion, de	nd place, at ath occurre	nd due to the d at the time	e cause(s	s) and manr nd place, an	ner as stated. ad due to the cause	(s)
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	edical	(check only	1		Carried Control			_				200. 00	I I	violiti, Day, Teal)	
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	iryland show	_	10a. State 10b. Co		10c. City	y, Town or Lo	ocation					10d. Insi	ide City Limits
	the Ma	Director	Maryland An	ne Arundel	Ann	apolis				1.0 0			Yes 2 □ No
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36	72 hours after death with the Maryland Inatural", or items 23a or 28a-f show digal Examination at be mothered	by Fi	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Dive	Armed For Married 1.00 Armed For 1.0	2 □ No ve ates: 43-46		1 □Yes 2 XX No	Specify:	0.10.1		Specify:	White	e
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/lan	uld be Mental arked attc ev	To B	John Christan	n Myer				Margare	et E. Be	aker	,		
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ē,	Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show int of the traumatic event, the Medical Evan in a state to notified at		John A. Myer 20a. Method of Disposition	/son	20b. P	lace of Dispo	Butterf1 sition (Name of		Indian Date	Head	Md 2	0640_	ate
altimore, Maryland 21215-0036	permit. Pages Department of Important: If It any Injury or once.		1 XXxriał 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth	ition 3 🗆 Removal from S	State Mar	emetery, crer v Land	natory or other pla Veterans	ce)	26/2000		•		
Balti	permit. Departr Importa any Inju		21. Signature of Funeral Se	rvice Licensee			Name and Address						
	~ C = * 0		23a Part 1 Enter the direct	There	arrand the death		.6000 Ann				Maryla	-	
	Physician		Immediate Cause (Final	List only one complete on ea	ach line.	i. Do not en	A A	ng, such as card	lac or respiratory	arrest,		Interva Onset	ximate al Between and Beath
	/Medical		disease or condition resulting in death)	a. Que to (or as a consequ	uence pt):	- VIIV	1:		-		XM	andre
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	executed an and rial-transit	Examiner	Sequentially list conditions, if any, leading to immediate caus. Enter Universitying Cause (Disease or injury that initiated events	S Due to (or as a consequ	derice or):							
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B	e death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live c	oirth 2□ Fetal nant at time of do own		Dectopic pregnand Other (specify)	СУ			Month	Day	Year
P.O.	that the	Phy	9 ☐ Unknown Part II. Other significant co			ulting in the u	nderlying cause giv	en in Part I	23e. Did	tobacco	use contribute	to the cause	e of death?
rds	auires n sign ald be	d by									!□No 3□		
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Zit.	stclan s certif irector	Be c	25. Was case referred to me examiner? 1 ☐ Yes 2 No	Hoenital:		55/0:	ott	05:	eath (Check only				
υof	ig Phy ter this neral d	n: T	27. Manner of Death	28a. Date of	npatient 2 of Injury th, Day, Year)	28b. Time of Injury	IL 3 LI DOA	4 LI Nursing	28d. Describe			pecify) SO	n's res
sion	Attendir death. ctor: Af y the fur	catic	2 ☐ Accident in	vestigation			M 1 □	Yes 2 □No					
Division of Vital Records,	after d Direct Jin by	Certification: To		atermined 28e. Place	of Injury - At ho ng, etc. (Specify	me, farm, str	eet, factory, office		28f. Location City or To	(Street a wn, Stat	nd Number or . e)	Rural Route	Number,
			29a. Certifier 1 Certifier (Check only 2 Mee	tifyIng Physician: To the	best of my know	wledge, deat	h occurred at the ti	me, date and pla	ace, and due to th	e cause(s) and manner	as stated.	
	the H hin 24 the Fi	Medical	0110)		asis of examinatine stated.	tion and/or in			ccurred at the time				
	5 <u>v</u> vii o	-	29b. Signature and title of ce	ertifier	1) only	No	29c. Licens	se number	79	29d. Da	ate signed (Mo.	nth, Day, Ye.	ar)
	CXOLUT	1	30. Name and address of pe	erson who completed cause	e of death (Item	23a) (Type,	Print) A				10.	>/0	
	1/20 A		(TFed)	acrust	NAT	10/52	11/100	i Ch	NAN	Do	PV-1	Mix.	20603
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No.Z U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Day Year Thomas Anthony McMahon 2009 elesuan 24 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Doctors Community Hospital Lanham, Maryland 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign Country)
New York 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 1 X M 2 □ F Hours 154-16-3479 Director 07/06/1920 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Operarment of Health and "Bental Hygiene. Important; I fam 27 is marked other than "catural", or items 23a or 28a-1 show any injury to other traumatic event, the Medican Examine must be notified as Director Prince George's Maryland Bowie 1 **K X X S** 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12410 Shadow Lane 20715 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Nayy Year or Dates: 44-46 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🛣 No Specify: ⋛ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Personnel Director Dept. of the Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis T. McMahon Susanne Rebovich ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Thelma M.McMahon/wife 12410 Shadow Lane, Bowie, Maryland 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State National 03/17/2009 Arlington, Virginia
22. Name and Address of Facility Robert E. Evans Funeral Home
16000 Annapolis Road, Bowie, Maryland 20715 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility alle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Status Your Cardia arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Trut 105 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Be Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Vriknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy certificate perform 1 □Yes 21 completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of De Iti 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital within 24 hours a To the Funeral Medical (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year) MDD60925

State Registrar 31. Date filed (Month, Day, Year) FEB 26 2009

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2A beth

91186 ood Lucil Rd., Carham, MD. 20704 KA 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NANCY WILHELM MURRAY FEBRUARY 22 2009 11:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CHESAPEAKE WOODS CAMBRIDGE DORCHESTER 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Months Days Hours 1 □ M 2 **X** F 205-12-3750 Director 85 FEB. 19, 1924 PENNSYLVANIA Usual Residence of Decedent 10a. State r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notifled at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MARYLAND TALBOT ST. MICHAELS 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 9794 MARTINGHAM CIRCLE Funeral 21663 UNITED STATES Race - American Indian Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: WHITE 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 72 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 LEGAL OFFICE MANAGER LEGAL permit. Pages 1 and 2 should be filed v Department of Health and Menta! Hygie Important: If Item 27 Is marked other I any Injury or other traumatic event, <u>It</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM J. WILHELM 2 HARRIET BEAVER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANDREW GRAHAM/PERSONAL REPRESENTATIVE ONE SOUTH STREET, STE 2600, BALTIMORE, MD 21202 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State FEBRUARY 24 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 2009 STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one parse in each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Deal Physician zheime las ISEas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼No page 2 s 24a. Was an autopsy certificate 1□ Yes 2 **N**No Hospital or Attending Physician; director 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? 2 No 1 ☐ Yes Other: 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Inpatient this 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2□ Accident investigation 1 ☐ Yes 2 ☐ No after death Director: filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00 31. Date filed (Month, Day, Year Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

FEB 27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND, ITEM#5perINF, G890, 4/21709, WS
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year 1:45 ам Robert Dale Miller February 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Laurel Regional Hospital Laurel Prince George's 5. Social Security Number 7542 If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1⊠M 2□ F Director 273-14-89 February 15,1920 Ohio Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Everniner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☒ No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3112 Gracefield Road, #121 20904 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ⊠Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Completed by Specify: 3 ☑ Widowed 4 ☐ Divorced WWII White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 Engineer Goddard Space Flight Center ages 1 and 2 should be file ont of Health and Mental Hi t: If item 27 is marked oth y or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ Frank Edward Miller Anna Maria Inglish 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John C. Miller - Son 13726 Lakeside Drive, Clarksville, Maryland 21029 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 permit. Page Department of Important: If any injury or once. 1 ☑ Burial 2 ☐ Cremation 3 Pemoval from State 4 ☐ Donation 5 ☐ Other (Specify) 02/27/2009 Parklawn Memorial Park Rockville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Parkinson's Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Physician/Medical Examiner Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) detached þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Renal Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 🖺 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 X Natural 5 Pending 2 Accident investigation 1 □Yes 2 □No after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10+1 D24035 February 22, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugenio S. Machado, M.D., 3110 Gracefield Road, Silver Spring, Maryland 20904 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 27 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 8:50 Elizabeth Corbett Miller February 25, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 🗓 F Director 81 579-24-8275 Mar. 19, 1927 Washington, Usual Residence of Decedent 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mactical Examinar must be notified as Director 1 ☐ Yes 2/57 No MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 54 Regatta Bay Court, #118 21401 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No 3 Specify Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) iene. College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If item 27 is marked other than any Injury or other traumatin any once. Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dennis Joseph Corbett ပ Johanna M. Toomey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monica M. West /Daughter 15708 Wayne Avenue, Laurel, MD 20707 20c. Location - City or Town, State Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) March 2, 2009 1 Nation Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd., W., Silver Spring, MD 20901 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Box 68760. the attending physician the burial Physician/Medical IF FEMALE 23c. If yes, *o*utcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. detached 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 2 1 🗌 Yes 3 Probably 4 ☐ Unknown Completed been s cate has b page 2 sl 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ◯ No 24a. Was an autopsy certificate 2/XN0 Division of Vital 2/200 1 □Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specity)} \) 1∐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To funeral 27. Manner of Death After t 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29d. Date signed Month, Day, Year) 29b. Signature ar title of certific S cause of death (Item 23a) (Type,

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State

Registra

Year)

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31. Date filed (Month.

Registrar's Signature

		State of Maryland / Dep 1 - State Of Maryland / Dep State Of Maryland / Dep Co	partment of Health and N ertificate of Death	lental Hygier Reg.	ne 2009 08015
Physic		1. Decedent's Name (First, Middle, Last) KATIE ELIZABETH MARR		2. Date of Death Month FEB. 22	3. Time of Death 1541 M
/Med Exam		4a. Facility Name (If not institution, give street and number) Höly Cross Hospital	4b. City, Town, or Location of Death Silver Spring		4c. County of Death MONTGOMERY
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda, 216–18–0759 1 M 2 🗵 F 96 Yrs.		8. Date of Birth (Month, Day, Ye. Oct. 29,]	
5-UU36 72 hours after death with the Maryland hatural", or items 23a or 28a-f show dien Examinst must be notified at	ector	Usual Residence of Decedent	Location Silver Spring 10f. Zip Code	100	10d. Inside City Limits 1 □ Yes 2 □ No Citizen of What Country?
th with t	Funeral Director	102 Ritchie Avenue	20910	Tog.	U·S.A.
BAITIMORE, Maryland 21213-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Madral Examination and any or other traumatic event, Its Madral Examination and any or other traumatic event, Its Madral Examination and any or other traumatic event, Its Madral Examination and any or other traumatic event, Its Madral Examination and any or other traumatic event, Its Madral Examination and any or other traumatic event, Its Madral Examination and or other traumatic event, Its Madral Examination and other traumatic event, Its Madral Examination and other traumatic event, Its Madral Examination and other traumatic event.	by Fune	11. Marital Status 1 □ Never Married 2 □ Married This is a status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spin If Yes, specify Cuban, Mexican, Puerto □Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
within 72 hours affene.	Completed		pedent's Usual Occupation we kind of work done during most of work DO NOT use retired) Domestic	ing 16b	Kind of Business/Industry Home
yland Z vuld be filed v Mental Hygi arked other atic event, II	Be Co	17. Father's Name (First, Middle, Last) Arthur Pratt	18. Mother's Nam	e (First, Middle, Maid	len Surname)
aryla aryla should and Mer s marke	욘	19a. Informant's Name/Relationship (Type. Print) 19b. Ma	iling Address (Street and Number or Ru	ral Route Number, Ci	ty or Town, State, Zip Code)
or other tra		20a. Method of Disposition 1 St Burial of Disposition 1 St Burial of Disposition 1 St Burial of Disposition 20b. Place of Disposition 20c. Removal from State	position (Name of ematory or other place)	Date 20c	Spring, MD 20910 Location - City or Town, State
Ealtimor permit. Pages Department of Important: If Its any injury or o	olice.	4 □ Dongligh 5 □ Other (Specify) CTATE OI 21. Signature of Funeral Service. ic.,nsee		OWDEN FU	Silver Spring,MD NERAL HOME, P.A. Ekville, MD 20850
		23a. Part Enter the disease, or complications that caused the death. Do not eshock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
ficate be executed in plants of the burial-transit is the burial-transit in plants of the buri		disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of). Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Atrial fibrillation Raid Ventricular F Ilation with R	with Esponse	
BOX eath certi	sician/Me		3 ☐ Ectopic pregnancy 5 ☐ Other <i>(specify)</i>		23d. Date of delivery Month Day Year
et g	d by Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the cause of death? 2 🗽 No 3 □ Probably 4 □ Unknown
The lar	Completed			24a. Was an autopsy performed 1 ☐ Yes 2 🔀	24b. Were autopsy findings available prior to completion of cause of death? No 1 \(\subseteq Yes \) 2 \(\subseteq No \)
OT VITAL P Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Nopatient 2 ER/Outpat	Othor:	h (Check only one)	e 6 ☐ Other (Specify)
ION OT VITA nding Physician: ath. r: After this certific e funeral director,	11-	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 2 Accident investigation	of 28c. Injury at	28d. Describe how in	
To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	and Number or Rural Route Number, ate)
e Hospi 24 hou e Funer	edical	29a. Certifier (Check only one) **Certifying Physician: To the best of my knowledge, de control on the basis of examination and/or and manner stated.			
To the within comp	Me	29b. Signature and title of certifier	29c. License number D67279	29d.	Date signed (Month, Day, Year) 2/23/09
		30. Name and address of derson who completed cause of death (Item 23a) (Type S. Alagarsamy, M.D. 1500 For	e, Print) Cest Glen Rd. Si	lver Spr	ring, MD 20910
S Regis	tate strar	31. Date filed (Month, Day, Year) 32. Registrar's Signature		<u>.</u>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08016 State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Cheryl L. Martin 2009 February 22 2215 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Clinton Southern Maryland Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Social Security Number **Funeral** Months Days Hours 1 ☐ M 2 🖺 F Maryland Director 52 579-74-6699 January 31, 1<u>95</u>7 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Machine Event. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Director Prince Georges MD Temple Hills 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 20748 3882 26th Avenue Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No ģ Yes, Give Specify 3 Widowed 4 □ Divorced Year or Dates Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Retail Store Administrative Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ Clarence R. Jones Adele C. Franklin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3882 26th Avenue, Temple Hills, MD 20748 Ronnie Martin, Jr. - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Southern Mem. Gardens 2/28/2009 Dunkirk, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gladys Sewell Funeral Home, P.A., 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final S **Physician** TZ Me 5 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CIN 0 Sequentially list conditions, if any, leading to influediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dusito (or as a consequence of). Examiner requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 □ Yes 2 □ No
9 ☑ Unknown 4 Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a detached f signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been si e 2 should t Pulmondry Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an The law page performed certificate 1 □Yes 2 No To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day,

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32. Registrate Signature

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Physician

Director

Funeral

Be Completed by

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Examine

Physician/Medical

Be Completed by

Physician /Medical Examiner

	Please								Copies Ar	_	le.		
For State Registrar		State of	Maryland		artmen <i>rtificat</i>			l Me	ental Hygie Reg.	- C U	09	08	3017
1. Decedent's Name	e (First, Middle, La	ist)							2. Date of Death		, 1	3. Time	of Death
Lou	ise Omar	English	Miner						Month February	^{Day} 26, 20	009	9:0	5 P M
4a. Facility Name (I	f not institution, giv	e street and numb	er)		4b. City,	Town, or	Location of Dea	ath		4c. County o	f Death		
Shady G	rove Adv	entist H	ospital	L	R	ockv	ille			Mont	gome	ry	
5. Social Security N			Age (In yrs. la	• • • • • • • • • • • • • • • • • • • •	If Under Months		If Under 24 Hr Hours Mir	n	8. Date of Birth (Month, Day, Ye	ar)	9. Birthpla	ace (State	e or Foreign
215-58-94	.25	1□M 2 X F	61	Yrs.					June 10,	1947 N	North	Car	olina
Usual Residence of 10a. State	Decedent 10b. County		10c City	Town or Lo	cation						10	d. Inside	City Limits
	,										1.0		s 2K No
Maryland	Montgom	ery	L	amasc	us 10f. Zip	Codo			100	Citizen of Wh	nat Count		
10e. Street and Nur		011. n	. 1		101. Zip		70		log.			ıy:	
	etnesda	Church Ro		140	Wes Dass	208		/C===	sift Vac on No	U.S.A.		n Indian	
11. Marital Status		12. Was Decede	es?	. 13.	If Yes, spec	cify Cuba	ispanic Origin? In, Mexican, Pue	erto R	lican, etc.)		White, et		
3 ☐ Widowed	ied 2[XMarried	1 ∐Yes 2 If Yes, Give Year or Date	Z 140		1 ☐ Yes	2 X No	Specify:			Specify:	Whi	.te	
	15. Decedent's E			16a, Dece	dent's Usua	al Occup	ation		16b	. Kind of Bus	iness/Indu	ustrv	
	cify only highest gr	ade completed)		(Give		rk done d	during most of w	orkinį					
Elementary/Seco 9th	ndary (0-12)	College (1-4	or 5+)	Bin	dery	Work	er		P	rintin	ig Co	mpan	v
17. Father's Name	(First, Middle, Last	')					18. Mother's Na	ame	(First, Middle, Maid				7
Raleig	h Engli	sh					Laura	.]	Belle Ef	fler			
19a. Informant's Na	ame/Relationship	(Type. Print)		19b. Maili	ng Address	(Street	and Number or I	Rural	Route Number, Ci	ty or Town, S	tete, Zip (Code)	
Michael	T. Mine	r - Husba	and	1031	4 Bet	hesd	a Churc	h I	Road, Dam	ascus.	Mar	vlan	d 20872
20a. Method of Disp	position		20b. Pla	ace of Dispo	sition (Nar	ne of		Da		. Location - C			u 20072
	XCremation 3 ☐ 5 ☐ Other (Speci	Removal from St						2	/28/09 A1	exandr	ia.	Viro	inia
21. Signature of Fu				2:	2. Name ar	nd Addre	ss of Facility						
7111	Tu Kl.	Deres	n 1		olesw 6401	orth Rido	-Willia	ms T	P.A., Fu Damascus.	neral	Home	208	72
23a. Pari 1. Enter ti	he disease, or com	plications that cau	sed the death.									Approxim	ate
shock, or hea immediate Cause (one cause on eac										Interval B Onset an	
disease or condition resulting in death)	in 🕡		nonary as a consequ		<u>ac Ar</u>	rest							
	1	_ `			1								
Sequentially list con	nditions,		ra Cran		morrn	age_					_		
if any, leading to im cause. Enter Unde Cause (Disease or	injury	·	•	,									
that initiated events resulting in death) I		C. Due to (or	as a conseque	ence of):									
	l	d											
		u											
IF FEMALE: 23b. Was decedent	t pregnant	23c. If yes, outco								23d. Date	of deliver	v	
in the past 12	months?		th 2□Fetal nt at time of de		⊒ Ect <i>o</i> pic p ⊒ Other <i>(</i> s <i>t</i>		у			Mont		Day	Year
9 Unknown		9 ☐ Unknov	vn										
Part II. Other signif	ficant conditions	contributing to dea	th but not resul	Iting in the u	nderlying c	ause giv	en in Part I.		23e. Did tobaco	co use contrib	oute to the	e cause o	f death?
								_	1 ☐ Yes	2 🗆 No 3	B ☐ Proba	ıbly 4	Unkn <i>o</i> wn
									24a. Was an	24h W	ere auton	sy finding	ıs available
								_	autopsy	l? pri	eath?		s available cause of
25 Mas sac= ==/-	rod to modii	1					00.5:		performed	No 1	□Yes a	2 🗆 No	
25. Was case reference examiner?		Hospital: X				Oth	Or:		(Check only one)				
1 ☐ Yes 2 ሺ 27. Manner of Deat		28a. Date of	oatient 2 E	ER/Outpatie 28b. Time o		DA DA 28c. Injur	4 LI Nursing		e 5 Residence)	
1 XNatural 2 Accident	5 ☐ Pending investigation	(Month,	Day, Year)	Injury	М	Worl	yat (? Yes 2□No		og, pescribe now ii	njary boouried	•		
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place o building	f Injury - At hor , etc. <i>(Sp</i> ec <i>ify</i>	me, farm, str	reet, factory	, office		28	Bf. Location (Stree City or Town, S	t end Number tate)	r or Rural	Route No	ımber,
29a. Certifier (Check only one)			is of examinat						nd due to the caus d at the time, date				e(s)

(Check only one) 29b. Signature and title of certifier

29c. License number D0065505 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Qiufang Cheng M.D. 9901 Medical Center Drive, Rockville, Maryland 20850

h Pay Year) MAR () 31. Date filed (Month,

32. Registrar's Signature

M.D

		-	State o	f Maryland / Depa Cer	artment of Heatificate of De	eath	Reg. No. 2003	
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last)		Banion	2. Date of Month	Day Year	3. Time of Death 9:39 A M
)	Examin	er	4a. Facility Name (If not institution, give street and nun The Johns Hopkins Hospital 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	4b. City, Town, or Lo Baltimore C If Under 1 Year	FUnder 24 Hrs. 8. Date of	of Birth 9. Birth	thplace (State or Foreign
	Funeral Director		261-41-4189 1 M 2 F	50 Yrs.	Months Days H	Hours Min. (Month	n, Day, Year) Co	orida -
5-0036 72 hours after death with the Maryland	if Health and Mental Hygiene. item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Director	Maryland Frederick 10e. Street and Number	10c. City, Town or Lo	noxville		10g. Citizen of What Co	10d. Inside City Limits 1 Yes X No
Jeath with 1	ms 23a or must be n	Funeral Dir	1602 B. New York Ave.	edent Ever in U.S. 13.	2	21758 anic Origin? (Specify Yes o Mexican, Puerto Rican, etc	United S	tates erican Indian,
JUSO lours after o	ral", or iter Examiner	by	1 Never Married 2 Married 1 Married	2 No re ates:	1 ☐ Yes 2 🛣 No	Specify:	Specify: Wh:	ite
d 21213-0036 filed within 72 hours aft	ene. than "natu ne Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1	-4 or 5+) (Give	dent's Usual Occupation kind of work done dur. DO NOT use retired) chnician	ing most of working	Electro	•
	and Mental Hygid Is marked other anmatic event, th	To Be C	17. Father's Name (First, Middle, Last) Roy O'Banion, Jr.	,			Stewart	
	Health and Nem 27 is ma		19a. Informant's Name/Relationship (Type. Print) Gabriele O'Banion / Wife	1602	B. New Yo	rk Ave., Kno	xville, MD 21	758
more Pages 1	nent o		20a. Method of Disposition 1 □ Burial 2 🏋 Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify) 21. Signature 💁 Funeral Service Licensee	Stauffe	r Cremator 2. Name and Address		9 Frederick	, Maryland
Balti	Impor any in		23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on e	auther 1	100 N. Map	le. Brunsw	er Funeral Ho ick, MD 21716 tory arrest,	
760, te be executed W	nysician Medical Medical transit the prinar-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Due to Due Due to Due Due to Due Due to Due Due to Due Due Due Due Due Due	(or as a consequence of): (or as a consequence of): (or as a consequence of):		on .		Onset and Death
I Records, P.O. Box 68 The law requires that the death certifica	been signed by the attending phi should be detached for use as th	Physician/Me	in the past 12 months?	nant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of de Month	elivery Day Year
rds, P.	n signed by	b	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause give	n in Part I. 23e.	Did tobacco use contribute 1 ☐ Yes 2 ☐ No 3 ☒ F	
Il Records,	ate has bee page 2 sho	Completed				1 🗆	autopsy prior to death? Yes 2 ▼No 1 □ Ye	autopsy findings available ocompletion of cause of
of Vita	certificate director, pa	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☒	Inpatient 2 ☐ ER/Outpatien	Other:	26. Place of Death (Check of 4 ☐ Nursing Home 5 ☐	Residence 6 Cother (Spe	ecify)
Division of Vital	h. After fune		27. Manner of Death 1 ★ Natural 5 □ Pending 2 □ Accident investigation 2 (Mor	of Injury of Injury 28b. Time of Injury	Work?	s 2 🗆 No	cribe how injury occurred	
Divis	= E	Certification:	4 ☐ Homicide determined build	e of injury - At home, farm, st ling, etc. (Specify)		City	tion (Street and Number or F or Town, State)	
the Hosnital	24 hou Funer etely fil	edical	29a. Certifier (check only one) 1 🕱 Certifying Physician: To the 2 Medical Examiner: On the and ma	e best of my knowledge, deal casis of examination and/or it nner stated.	n occurred at the time nvestigation, in my opi	nion, death occurred at the	time, date and place, and d	ue to the cause(s)
J. C.	within 24 hours of the Funeral I completely filled	Me	29b. Signature and title of certifier ACLC MID		29c. License n		29d. Date signed (Mon	
)			30. Name and address of person who completed ca		e, Print)	600 North	Wolfe St, Baltim	ore, MD, 21287
	St	ate	31. Date filed (Month, Day, Year) 32. I	Registrar's Signature	1			

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 12:50pm 2 9 tarry /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner RENAISSANCE GARDENS CATONSVILLE BALTIMORE 8. Date of Birth (Month, Day, Year)
FEB. 7,1918 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1**X** M 2□ F 91 MARYLAND Director 214-05-0398 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Examiner must be notified at 1 X Yes 2 ☐ No Director MARYLAND BALTIMORE CATONSVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 713 MAIDEN CHOICE LANE APT. 1301 21228 UNITED STATES Funera 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 72 hours after 1 XYes 2 □ No If Yes, Give Year or Date 9.40-1945 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: 9 Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MASTER PILOT MARITIME 12 should be filed wi th and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be J. HARRY PORTER ROSIE CECILA PORTER ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If item 27 is 1 ISABEL GRACE PORTER/WIFE 713 MAIDEN CHOICE LANE APT.1301, CATONSVILLE, MD 21228 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) MARCHate Department of Important: If it any injury or conce. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State STEVENSVILLE CEMETERY 2009 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Metastatic Prostate disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Year Day 5 Other (specify) o. 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by the detach σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performe certificate 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D4437

Registrar

State

Choice Lane.

21228

, mo

711 34 Registrar's Sign

Maiden

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Boulin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Feb. 24, 2009 **Physician** 1505 Betty Taylor Phelps Jean Jacks /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital Olney Montgomery 8. Date of Birth 9 109 7 947 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Min. Months Days Hours 1 □ M 2 □ X Arkansas 450-94-7729 61 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a, State 10h Counts 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, in a Moder I Examiner must be notified at MD Montgomery Rockville Director 1X Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20853 4700 Levada Terrace USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces?
1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. em 27 is marked other than "natural", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: à White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrude Bea Thompson James Richard Jacks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. Randy Phelps/Husband 4700 Levada Terrace Rockville, Md. 20853 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Bemoval from State Memorial Park Cem 2/28/2009 Pine Bluff, AR. 5 ☐ Other (Specify) 4 Donation 21. Signatu PHILIP OF RENALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LARCINOMA HTWOM disease or condition resulting in death) LUNG /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 ☐ Other (specify) signed by the a d be detached for P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ⋧ 2 No 3 Probably 4 Unknown HEPATIC page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☒No 24a. Was an has autopsy certificate 2 □No 1 Yes Division of Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pletely filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD EBRUARY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

FEB 27 2009

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31. Date filed (Month, Day, Year)



PHILIP DRIVE.

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			1 - For State Registrar		State of Ma	aryland / De _l	ertificate of	Death	Weritarriy	Reg. No. 20	09	08021
	Physici /Medic		1. Decedent's Name Cal						2. Date of De	eath	Year	3. Time of Death 0322 M
N. S.	Examir		4a. Facility Name (If r	not institution, give	e street and number)		4b. City, Town,	or Location of Deat	th	4c. County of	of Death	
			Holy Cr		spital		Silv	er Spri	ng	Mont	gome	ry
	Funeral Director		5. Social Security Nur 246 – 24 –			e (In yrs. last birthda 92 Yrs.	Months Days		8. Date of Bir	2 th 1916	9. Birthpla	ce (State or Foreign y)
	pu *		Usual Residence of D	Decedent 10b. County		10c. City, Town or	Location				104	Lincida City Limito
	shov	٥	MD	Montgo	merv	,	Spring				100	d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	rect	10e. Street and Numb		Juict y	DIIVEI	10f. Zip Code			10g. Citizen of W	hat Countr	
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	ns 23	era	11. Marital Status	ver pri	12. Was Decedent I	Ever in U.S. 13	209 3. Was Decedent of		Specify Yes or No	USA 14. Race	- Americai	ı Indian.
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	Completed by Funeral Director	1 Never Married 3 Widowed 4		Armed Forces? 1	No	3. Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 ☐ Who		to Rican, etc.)	Black Specify:	, White, etc	>.
5-0	72 hc natu	etec	(Specifi	15. Decedent's Ed y only highest gra	lucation de completed)	16a. De	cedent's Usual Occu	upation e during most of wo	rkina	16b. Kind of Bus	siness/Indu	stry
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yla	2 should be filed was and Mental Hygie is marked other transmits event, In	ျာ	Willie	Devon					a Free			
Maryland	2 sh h and is m raum		19a. Informant's Nam		Type. Print) nes/grand		iling Address (Stree					
	is 1 and 2 of Health item 27 i		20a. Method of Dispo		ies/granc		070 1st		#863 Ne	20c. Location - C	•	
Baltimore,			1 🔀 Burial 2 🗆		Removal from State	Rosemon	position (Name of rematory or other pla nt Cemet	ery 3/0			•	
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Fund	eral Service Licen	See 2]	PHYTETE Ade 9241 Col	esstinal umbia B	I FUNE	RAL SERV	VICE ring	,P.A. ,Md20910
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P.O. Box 68	The law requires that the death certificat ate has been signed by the attending phyage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent p in the past 12 m 1 □ Yes 2 전 9 □ Unknown	onths?	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death	B⊟Ectopic pregnan 5⊟Other (specify)	icy		23d. Date Mon	of delivery	
	s that th		Part II. Other signific	ant conditions of	ontributing to death bu	ut not resulting in the	underlying cause gi	iven in Part I.	23e. Did t	obacco use contrib	bute to the	cause of death?
rds	quires n sign ald be	d by	hypei	rtensio	n, diabe	tes mel	litus		1 🗆 '	Yes 2 □ No 3	3 ☐ Probab	oly 4 🔀 Unknown
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Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investigation 6		ury - At home, farm, : c. (Specify)		Yes 2 □ No	28f. Location (3 City or Tox	Street and Number wn, State)	r or Rural F	Route Number,
	ne Hospital n 24 hours a ne Funeral I	Medical C	29a. Certifier 1 (Check only 2 one) 2	Certifying Ph	ysician: To the best of hiner: On the basis of and manner sta	f examination and/or	ath occurred at the investigation, in my	time, date and plac opinion, death occi	e, and due to the urred at the time,	cause(s) and man date and place, ar	nner as stat	ted. ne cause(s)
	To the within 2 To the complet	Me	29b. Signature and tit	tle of certifier	()	1	29c. Licen	se number		29d. Date signed	(Month, Da	ıy, Year)
	V		30. Name and addres	coresi	a AM	Grang and (Item 220) (To-	D56	691		Feb.2	20,20	009
					tana MD		leritage	Park C	ircle S	Silver S	prin	g,Md

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? \cap Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Feb 24, **Physician** 2009 2:15P M Isaac Riley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 9711 Ouiet Brook Clinton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours **X** M 2□ F Days 579 12 6910 84 Director July 14, 1924 South Carolina Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ns 23a or 28a-f show VA 1 ☐ Yes 2 X No Spotsylvania Spotsylvania Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 7635 Stubbs Bridge Road 22553 United States or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status of Health and Mental Hygiene.
Item 27 is marked other than "natural", or item other traumatic event, Inc. Medical Examination Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🔯 No Specify: <u>ک</u> Specify: Black ₩Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Plasterer Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gertrude Tittle Isaac Riley, Sr. ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau 9711 Quiet Brook Lane, Clinton, MD Linda Riley (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory Feb 25, 2009 Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home, inc e of Funeral 6633 01d m00251 Alexandria Ferry Road, Clinton, MD 20735 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mitral Valve Stenosis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): P.O. Box 68760, IF FFMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No 2 🗆 No ∣∐Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Daughter 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 1 X Natural 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 Tyes 2 □ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

1851

State Registrar DR DONA VESK 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

se of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 08023

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Physician/	Re	gistrar Decedent's Name (First,	Middle,Last)					1.5	Month	of Death Day	y Year		ime of Death 924 hrs
Medical Examiner		DELLA		REINSFE			o. City, Town, or	Location of De		h 4, 200	9 4c. County o		
	48	. Facility Name (if not ins	titution, give s	street and number))	41	Frostburg				Allegany		
Farmer	5	Social Security Number	6. Sex	7. Ag	ge (In yrs. last	birthday)	If Under 1 Yea			e of Birth (M	M/DD/YYYY)	9. Birthpla Foreign	ce (State or
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the Maryland a or 28a-f sh tiffed at once	1	De. Street and Number		777			21532				USA		
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215. 215. ntal Hy rked of	2	WILLIAM J	CLIFF					CATH	ERINE	M. YOU	JNG	- Ctato 7	n Code)
21, 21, ould be do Men s mar tic cve	2	9a. Informant's Name/Re				1	Address (Str						p Code)
Imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours ment of Heath and Mental Hygiene. fant: If item 27 is marked other than "natur or other traumatic event, the Medical Examination of December 170 Be Completed Items.	1	KAREN DIAM		UGHTER	20b. P	ace of Dispos	ALLEGAN ition (Name of c		P KUS 1.	BURG 1	MD 215	- City or To	wn, State
ore, of Hea of Hea If ite	1	1 Burial 2 X Cre	emation 3	Removal from S	State cr	ematory or ot	ner place)		. 16 120		CRESA	DTOUN	MD
Baltimore, permit. Pages 1 ar Department of Her Important: If ite Important: If ite Important or other tr		4 Dopation 5 0	her Specify	1	BCAR		NERAL HOM Name and Addre		3/ <u>6/20</u> SCARPE				
Baltir permit. P Departme Importar injury or	- 1	1 11 /	1 /	1 / 1/1	()	1.10	O TITOCI	NTT A A	CITA	TOTOT A	ND MD	21503	2
Physician	-	232 Part I. Enter the dise failure. List only one	ase, or comp	ications that cause	ed the death.	Do not enter t	he mode of dyin	g, such as card	trac or respir	atory arrest	, shock, or he	eart	Approximate Interva Between Onset and Death
aminer		Immediat / Cause (Final or condity in resulting in discountially list condition if any, leading to immedia cause. Enter Underlying (Disease or injury that injevents resulting in death	ns, ate Cause tiated	Due to (or as a con	nsequence of): - -	Icaleu I	y positi	CIONA	азр	, 11 Lu		
be executed sician and ourial - transit	ᇎ	₹ INDENDED	d.	AMENDED 2:	3a,PII	,27,28	a-f, per	rME, g8	89 3/	6/09	TT		
ob, e be execut ysician and burial - tra	edical	X UNPENDED	ļ	23c. If yes, out							23d. Date		
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be e. 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicia tely filled in by the funeral director, page 2 should be detached for use as the buriated.	Physician/M	IF FEMALE: 23b. Was decedent pregr past 12 months?		1 Live birth 4 Pregnant	n t at time of de	2 F	etal death other (Specify)	3 Ectopic p	pregnancy		Month	Da	y Y ear
O. Box at the death of the attentached for us	ج	Part II. Other significan		0		esulting in the	underlying caus	se given in Part	:1.				e cause of death?
P.O.	≦	Asthma							L				bly 4 Unknow
ords, v require s been si	Completed								:	24a. Was a autops	У	prior to co	psy findings availa mpletion of cause o
of Vital Records, g Physician: The law requir (Net this certificate has been s meral director, page 2 should	d d									yerform ✓ Yes 2		death? 1 ✓ Yes	2 No
tal Rec		25. Was case referred to	medical	_			26.P	ace of Death (C	Check only o			-	
/ital	o Be	examiner?		Hospital: 1 Inp	patient 2	ER/Outpatie			Nursing Hor		Residence 6		
n of \ing Phy	\vdash	27. Manner of Death	_	28a. Date of (Month, D	Injury Jay,Year)	28b. Time o	f Injury 28c.	Injury at Work?			wedge		ween
ion tendii tor: /	atio	1 Natural 5 2 X Accident	Pending Investiga	tion Fd 3/	4/09	unk				eelch	air an	d bed	al Route Number, C
Division pital or Attendit ours after death.	Certification:	3 Suicide 6	Could no	t be		iome, tarm, st	eet, factory, offi	ce building, etc	. 201.	or Town, St	ate) 63 V	ictor D	al Route Number, C ia Ln.
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the 1		4 Homicide 29a. Certifier 1 Cert (Check only one)	ifying Physical Examine	cian: To the best of	nome of my knowled	ige, death occ	curred at the time	e, date and place nion, death occ	ce and due	to the cause	e(s) and man	ner as state	d.
To the within 2 To the complet	Medical	29b. Signature and title		and manner sta	ted.			cense number			29d. Date s	igned (Mon	th, Day, Year)
	2	290. Dignature and title	0				0	.C.M.E.			March 5,	2009	
		1 Carl	utech	()	of death (Itel	m 23a)							
		30. Name and address	of person who	o completed cause	- ·	444 =	04 5	altimore KAT	D 21201				
		30. Name and address Laron Locke M	of person who	stant Medical	Examiner	111 Pe	nn Street, B	altimore, MI	D 21201				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 25, **Physician** 2009 6:40 p February Quentin Raymond Stuck /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11704 Joseph Mill Road Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 3, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** Months Days Hours **№** M 2 🗆 F 1954 54 Virginia 505-62-6957 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10d. Inside City Limits show in than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 □Yes 2 No Director Maryland Montgomery Silver Spring 10f, Zip Code 10g. Citizen of What Country? 10e Street and Number 20906 USA 11704 Joseph Mill Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 ∐Yes 21€ No If Yes, Give Year or Dates; 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2XCXNo Specify. ۵ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Banker Finance 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) h and Mental F 1 and 2 should be Doris Risch Raymond Stuck ပ 19a. Informant's Name/Relationship (Type. Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and Department of Health an Important: If item 27 is any injury or other traus Anita M. Stuck/Wife 11704 Joseph Mill Road, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State March 2 nlace Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 Silver Spring, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licens Francis J. Collins Funeral Home Inc. 500 University Blvd., W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Heratic Encephalopathy /Medical Due to (or as a consequence of) Examiner Laennec's Cirrhosis Sequentially list conditions, if a y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, law requires that the death certificate be Physician/Medical as attending use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) □Yes 2□No the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autonsv Physician; The perform 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home SPAResidence 6 ☐ Other (Specify) 1 ☐ Yes 2x No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P s after death. I Director; After 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe February 26, 2009 D55522 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910 Robert Gerard, MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 () () 9 08025 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 9:20 am February 25, 2009 Joseph /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Potomac Valley Wellness & Rehab Center Rockville Montgomery 8. Date of Birth (Month, Day, Year) August 7, 1926 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6. Sex **Funeral** Days 1 🛛 M 2 🗆 F Hours Director 111-18-4408 82 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item any injury or other traumatic event 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Rockville Maruland Montgomery 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 5428 Marlin Street 20853 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 124 Yes 2 □ No If Yes, Give Year or Dates: WW I I 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pharmacist Federal Government 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julius Stone Jennie Koplik 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan G. Stone - Wife 5428 Marlin Street, Rockville, Maryland 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lebanon Cemetery | 02/27/2009 5 ☐Other (Specify) Adelphi, Maryland 4 Donation 22. Name and Address of Facility
Hines Rinaldi Funeral Home, 21. Signatur Inc. 11800 New Hampshire Ave; Silver Spring, MD 20904 sed in death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Pa t1. Enter the iseas, or complications that shock, or heart failure. List only one cause of Approximate Interval Between Onset and Death Few Years Immediate Cause (Final disease or condition resulting in death) **Physician** Advanced Dementia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Parkinson's Disease 1 ☐ Yes 2 🔯 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 X No 1 ☐ Yes 2 🗆 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 🛛 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ∐Yes 2 🗓 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 🛛 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number February 25, 2009 D38262 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20,850 2401 Research Blvd., Suite 330, Rockville, M.D., F.A.C.P., Anurita Mandhiratta. 31. Date filed (Month, Day, Year) Registrar's Signature State Registra

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 24, 2009 9:15 a **Physician** William Seeley, III Grinnell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14914 Hydrus Road Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y OCt. 23, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1952 Hours Months Days Min. 1**™** M 2□ F Maryland 213-58-7601 56 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experiment must be notified at 1 ☐ Yes 2 1 No Director Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20906 USA 14914 Hydrus Road Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 XXIO 14. Bace - American Indian. Black, White, etc 1 Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Route Manager Washington Post 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of Doris Jean Crocker William Grinnell Seeley, Jr. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6701 Kirkley Avenue, McLean, VA 22101 Jean Romaine Seeley Holler/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 28, 20c. Location - City or Town, State 20a. Method of Disposition **ĕ**:**=** ō 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department Important: If any injury or once. Parklawn Memorial Park 2009 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 Univeristy Blvd., W., Silver Spr 21. Signature of Funeral Service Licensee W., Silver Spring MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute Gastric Bleed Minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 2 ½ years Kidney Cancer Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending p use as IF FEMALE: yes, outcome of pregnancy
Live birth 2 ☐ Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) sbeen signed by the should be detached 1 □Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2X ☐ No 3 ☐ Probably 4 ☐ Unknown Hypertension, Morbid Obesity Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has to autopsy performed? Yes 2 ⊠No certificate 1 ☐ Yes 1 ☐ Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural s after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 25, 2009 D10298 ID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roy H. Sandstrom, MD 7701 Carroll Avenue, Takoma Park, MD 20912 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 27 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Salazar Ofelia Josefina 2009 February 12:40 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 M 2 K F Director 84 227-51-9431 Dec. 18, 1924 Colombia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the five first for item to its filled at 28a-f show Director 1 ☐ Yes 2X No MD Germantown Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 1 20874 Colombia 18809 Sparkling Water Drive Apt 101 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ty Yes 2 No Specify: Colombian If Yes, Give Year or Dates: White 2 3 X Widowed 4 Divorcer Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f. Jose Gallego ပ Carmen Rosa Ortiz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 2087 permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau 18809 Sparkling Water Drive, Apt 101, Germantown Ines Salazar/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition February tX Burial 2 ☐ Cremation 3 ☐ Removal from State All Souls Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 28, 2009 Germantown, MD 22. Name and Address of Facilit 21. Signature of Funeral Service Licensee DeVol Funeral HOme, 10 East Deer Park Drive, TEACY 4 Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Pneumonia week /Medical Due to (or as a consequence of): Examiner Acute Renal Failure 1 week Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner requires that the death certificate be executed Sepsis 1 week burial-transi and resulting in death) Last Due to (or as a consequence of): tending physician a Box 68760. Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a P.0. 1 ∐ Yes 2 😾 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law certificate has page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🔀 No Attending Physician: 25. Was case referred to medical director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2∭ No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 X Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 24, 2009 67238 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Payam Chini, M.D., 9901 Medical Center Drive, Rockville, MD 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 27 Registrar

Physician	
/Medical	
Examiner	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Machical Eventhat in at the notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

_	1 - State Registrar		•	tificate of L		Reg.	No. 2009	9 08028	
ın	1. Decedent's Name (First, Middle, Last) Daniel Webster Shoemaker 2. Date of Death Month Day Year February 25,2009 12:03 P								
al er	4a. Facility Name (If not institution, give st			4b. City, Town, or	Location of Death		4c. County of Dea		
	4105 Jefferson P			Jeffer			Frederi		
	5. Social Security Number 219-54-4364 Usual Residence of Decedent	M 2□ F 7. Age (In yrs. las	st birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Jan. 24,	^{9. Bi} 0 1950 Ma	rthplace (State or Foreign Country) aryland	
	10a. State 10b. County	10c. City,	Town or Loc	cation				10d. Inside City Limits	
cto	Maryland Frederi	.ck J	effer	rson				1 □Yes 2 No	
Dire	10e. Street and Number			10f. Zip Code			Citizen of What C	,	
eral	4105 Jefferson P	2. Was Decedent Ever in U.S.	12 1		1755		ited St		
Completed by Funeral Director	11. Marital Status 1 Never Marrled 2 Married 3 Widowed 4 Divorced	2. Was between Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 1969 If Yes, Give Year or Dates: 1973	9- 1	Vas Decedent of Hi Yes, specify Cuba □Yes 2 XX No	Specify:	Rican, etc.)	Black, Whi	te, etc.	
letec	15. Decedent's Educa (Specify only highest grade	ation completed)	16a. Deced	ent's Usual Occupa kind of work done d OO NOT use retired	ation Juring most of work	ing 16b	. Kind of Business	s/Industry	
dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		•)		D.		
	17. Father's Name (First, Middle, Last)		EII	gineer	18. Mother's Nam	e (First, Middle, Maid		oduction	
o Be	Louis W. Shoemak	er, Sr.			Lola M	. Smith	,		
17.00	19a. Informant's Name/Relationship (Type Gloria Shoemaker					ral Route Number, Ci e, Jeffe			
	20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Qther (Specify)		thaven	sition (Name of latory or other place Cremator	су Гоб	. 26, 2009 Fre		, Maryland	
	21. Signature of Funeral Service Licenses		Re 95	Name and Address esthaver 501 Cato	s of Facility n Funera octin Mt	al Servic n. Hwy. H	es, Skk 'rederi	ot Cody P.A.	
	23a. Part 1. En er the disease, or conviction shoot or heart failure. List out one immediate Cause (Final disease or condition	ations that caused the death. cause on each line.						Approximate Interval Between Gnset and Death	
	resulting in death)		1)						
į.	Sequentially list conditions, b.		month						
edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque							
Exa	resulting in death) Last	Due to (or as a conseque	ence of):						
lical	d.								
5	IF FEMALE:	c. If yes, outcome of pregnance	cv	· · · · · ·					
Physician/	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	1 Live birth 2 Fetal d 4 Pregnant at time of dea	death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year	
	Part II. Other significant conditions contr	ributing to death but not result	ting in the un	derlying cause give	n in Part I.	23e. Did tobacc	o use contribute t	to the cause of death?	
edt						1 ☐ Yes	2 ☑ No 3□F	Probably 4 Unknown	
Completed by						24a. Was an autopsy performed	prior to death?		
Be C	25. Was case referred to medical examiner?								
	1 ☐ Yes 2 ☑ No ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ☐ Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)								
27. Manner of Death 28a. Date of Injury 28b. Time of Injury									
Certifi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (Street City or Town, St	and Number or Fl ate)	Rural Route Number,	
edical		cian: To the best of my knowler: On the basis of examination and manner stated.							
2	29b. Signature and title of certifier HEGAN	nw 2/2/	266	29c. License	HUH	29d.	Date signed (Mon	th, Day, Year)	
	30. Name and address of person who com	npleted cause of ath (Item 2	23a) (Type, P	Print)	wy Surts	200 Fred	DY 1 Y N	D 51702	
е	31. Date filed (Month, Day, Year)	32. Registvar's Signatur	ire	Harrie	-2 /1110		U11 02 1.		
	a fit is the straight on a	1	5 64						

09-015	25`	
Dennis	Ray	Slate

nnis Ray Sla		Sta 1- For State Registrar	ate of Marylar		rtment of tificate of		nd 	Menta	ıl Hygi		Reg. No.	200	
Physici edical Exam	an/	Decedent's Name (First, Middle		nnis Ra	y Slate	r			1	Date of Dea Month ebruary	Day 21, 200		3. Time of Death 0625 hrs
		4a. Facility Name (if not institution 12724 Greencastle Pil	_	iber)	41	o. City, Town, Hagerstov		cation of I	Death		1	county of Deat ashington	1
Funeral Director		5. Social Security Number 2 18-40-4074	6. Sex 7	7. Age (In yrs. Ia		If Under 1 Y Months D	ear ays	If Under 2 Hours	Min.	. Date of B June	,	Co	thplace (State or Foreign buntry) 'est Virginia
any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Location	on							10d. Inside City Limits
	J.	Maryland Washington Hagerstown									1 Yes 2 No		
Maryt: r 28a-f ed at o	rect	10e. Street and Number				10f. Zip Code				7 1		n of What Cou	intry?
ith the	al Dir	607 South Potomac Street 21740 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe						? (Specil	fy Yes or N		J . S . A . 4. Race - Ame	ican Indian, Black,	
ifter death with the Maryland 1", or items 23a or 28a-f sho ner must be notified at once,	by Funeral	1 Never Married 2 X Ma 3 Widowed 4 Div	ces?	If Ye	es, specify Cub Yes $2X$	oan, M	Mexican, P				White, etc.	hite	
36 in 72 hours a han "nature lical Exami	eted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) Truck Driver								16b. Kir	nd of Business. Trucki		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heabh and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho hijury or other traumatic event, the Medical Examiner must be notified at once.	Be Com	9 17. Father's Name (First, Middle, Roy Dennis				z dest 2		.Mother's		rst, Middle,			
21 Should: I nd Mer is mar	P	19a. Informant's Name/Relations		<i>c</i> ,		Address (St							
m, MI and 2 s leabh a tem 27		Theresa L. Sla 20a. Method of Disposition	ter (Wi	20b. F	Place of Disposi	tion (Name of			D	gerstown, Maryla Date 20c Location - City			
nore ages 1 ant of H other		1 Burial 2 X Cremation		III State	crematory or oth ithsbur		ato	oru .		ruary 2009		ni thsbu	rg, Maryland
altin	-	Donation 5 Other Str. Signature of Funeral Service	Licensee		22. N	ame and Addr	ess o	f Facility		J.L.	Davi		ral Home
		23a. Part I. Enter the disease, or	DAVIS	MO 14									ryland 21783 Approximate Interval
Physician /Medical xaminei	e 77	failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	es									Between Onset and Death
		Sequentially list conditions,	b										
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause c.											
ted 1 ansit	Exar	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of	f):								
50, te be executed nysician and e burial - transit	edical	UNPENDED	X AMENDED	X _{AMENDED} 28b,c per me,g889,03/13/09dhb									
vrds, P.O. Box 68760, vrequires that the death certificate by seven signed by the attending physic should be detached for use as the bur	Physician/Me								ry Day Year				
P.O. E es that the igned by the be detached	d by Ph	Part II. Other significant condit	tions contributing to	death but not re	esulting in the u	nderlying caus	se giv	en in Part	t I.			se contribute t	o the cause of death? obably 4 Unknown
of Vital Records, ig Physician: The law requin wher this certificate has been someral director, page 2 should?	Completed								_		opsy formed?	prior to death?	
tal R :iant T :certific	Be C	25. Was case referred to medica examiner?	I I ital					of Death (Cother					
of Vit Physic ler this	2	1 ✓ Yes 2 No 27. Manner of Death		of Injury	ER/Outpatient			at Work?	Nursing I			ry occurred	er: Scene
ion C fending eath. or: Aft	tion	1 Natural 5 Pen	ding Feb 21, 2	Pay Year) 2009	6:30a	1	XYe	es 2	No Pe	edestriar	struck	by auto	
ivisi or At after d Direct	ٽ ا [ِ]	3 Suicide 6 Cou	ld not be	of Injury - At he Parking Lo	ome, farm, stree	et, factory, offic	ce bu	ilding, etc.				id Number or F Pike, Hagerst	Rural Route Number, City
the Ho hin 24 the Fu	Medical	29a. Certifier 1 Certifying P	hysician: To the besi miner: On the basis of and manner st	of examination a	ge, death occur ind/or investigat	red at the time ion, in my opir	e, date	e and plac death occi	e, and du urred at th	ie to the ca ne time, dat	use(s) and e and plac	manner as sta ce, and due to	ated. the cause(s)
To with	Me	29b. Signature and title of certification				29c. Lic	ense C.N					eate signed (M	onth, Day, Year)
		30. Name and address of person	who completed caus	e of death (Item	23a)		U.IV			_			
		Pamela E. Southall, N	MD Assistant I	Medical Exa	miner 11	1 Penn Str	eet,	Baltimo	ore, MD	21201			
	State	31. Date filed (Month, Day Year)	32. Re	gistrar's Sigrati	ure back	1							

			State of N	Maryland / Depa				000	0.0000		
			Registrar	Cei	rtificate of L	Jeath	2. Date of Dea	Reg. No.	3. Time of Death		
	Physicia	an	Decedent's Name (First, Middle, Last) Part C	77 - 7 7			Month	Day Ye	ear		
17	/Medic		Pat G. 4a. Facility Name (If not institution, give street and number	. Valley	4b. City. Town, or	Location of Death	Feb	24 20 (4c. County of I			
1	Examin	er				aston			lbot		
	Funeral Director	4	Genesis HealthCare 5. Social Security Number 125-10-7961 7.	The Pines Age (in yrs. last birmaay) 99 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	h a	Birthplace (State or Foreign Country) New York		
1	ס	1	Usual Residence of Decedent								
	arylar show d at	_	10a. State 10b. County 10 Talbot	St. Mich					10d. Inside City Limits 1¥CXYes 2 ☐ No		
	he Ma 8a-f	Director			10f. Zip Code			10g. Citizen of Wha			
	a or 2	ä	10e. Street and Number 113 Mitchell Street Ap	a±6_A	21163			USA	it Country:		
	eath rs 23 must	eral	11. Marital Status 12. Was Decede			ispanic Origin? (Sp	ecify Yes or No-		American Indian,		
36	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	by Funeral	Armed Force 1 □ Never Married 2 □ Married 1 □ Yes 2 ∑ 1 □ Yes 3 ∑ Widowed 4 □ Divorced 1 □ Yes 7 Date:	∑ No	Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2500No	n, Mexican, Puèrto Specify:	Rićan, etc.)	Specify:	White, etc. White		
ŏ	2 hou	Completed by	15. Decedent's Education	16a. Dece	dent's Usual Occupa	ation	da a	16b. Kind of Busin	ess/Industry		
215	thin 7 e. an "n Medi	ble	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4c	or 5+)	kind of work done of DO NOT use retired		ing				
7	ed wil ygien ier th	Son	12	Profe	ssional D			Entertai	nment		
nd	be filled that the descent	Be	17. Father's Name (First, Middle, Last)					Maiden Surname)			
Z	ould I Men narke natic	은	Francesco Valley	405 14-16	- Add (Ot		Muccho		7-0-4-1		
Mai	id 2 sh ith and 17 is n traun		19a. Informant's Name/Relationship (Type. Print) Ms. Pat Davis Dau		-			er, City or Town, Sta St. Mich	aels, Md 21163		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 25 Cremation 3 Removal from Sta	ile	esition (Name of matory or other plac c Cremato		Date 6/2009	20c. Location - Cit	•		
計	artme artme ortani Injury	1	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		2. Name and Addres Obert E.				mie, nu		
Ba	Depa Impo any Ir	U	allen An 33		obert E. 6000_Anna				1 5		
E C	Physician	9 5	23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition	sed the death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death		
h	/Medical Examiner		resulting in death) Due to (or	as a conseque (ce of):	sterty	,			7		
16.	Examiner	Ļ	Sequentially list conditions, b. ———————————————————————————————————	1	st woo	ma	430		30 years		
	bed sit	Examiner	cause. Enter Underlying Cause (Disease or injury	as a consequence of):							
	execu and al-tra	xar	that initiated events c	as a consequence of):							
8760,	cate be executed ohysician and the burial-transit	dical 8	d								
9		ledi			•						
. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Med		n 2 ☐ Fetal death 3 [t at time of death 5 [⊒Ectopic pregnancy ☑ Other (specify)	,		23d. Date o Month			
P.0.	requires that the reen signed by the	hys	9 Li Unknown				00 0111				
	w requires that s been signed to should be det	by	Part II. Other significant conditions contributing to death	n but not resulting in the u	nderlying cause give	en in Part I.			te to the cause of death? ☐ Probably 4 ☐ Unknown		
orc	requi	Completed	110 100 100 100 1	V			1				
Sec.	aw as b	nple	A/2pliners	Serrenca			24a. Was autop	an 24b. Wei osy prio ormed? dea	re autopsy findings available r to completion of cause of		
al F	ate pag						1□ Yes	2 1 No 1 □	Yes 2 □ No		
Zit.	Physician: The I rthis certificate ha ral director, page	Be	25. Was case referred to medical examiner? 1 Tyes 2 No Hospital: 1 Tinp.		othe Othe	er: Place of Deat					
ō	Phys r this eral dii	.: To	27. Manner of Death 28a. Date of I	atient 2 ER/Outpatienniury 28b. Time o	" OLI DON	4 Liz Nursing H		dence 6 Other ((Specify)		
O	Attending r death. ector: After by the funer	tion	1 ☑ Natural 5 ☐ Pending (Month, 2 ☐ Accident investigation	Day Year) Injury		k? Yes 2 ☐ No					
Division or Vital Records,	- 4.5	Certification:	3 Suicide 6 Could not be 28e. Place of	injury - At home, farm, streetc. (Specify)	reet, factory, office			on (Street and Number or Rural Route Number, Town, State)			
	To the Hospital of within 24 hours aft To the Funeral D completely filled in		29a. Certifier 11 Certifying Physician: To the be	est of my knowledge, door	h occurred at the tin	me date and place	and due to the	cause(s) and mann	er as stated		
	e Hos 24 hc e Fun letely	Medical	(Check only one) Check only one) Certifying Physician. To the basi one Certifyi	s of examination and/or in							
	To the To the To the To the To the Comple	Me	29b. Signature and title of certifier		29c. License	e number		29d. Date signed (A	Month, Day, Year)		
		7	► //4500)		H42	587		02-24	-2009		
	2000	\sim	30. Name and address of person who completed cause of								
	0.15		RUSCELL A Schilly Di		wood A	Basto	n mD	21601			
	Sta Regist		31. Date filed (Month, Day, Year) 32. Reg	istrar's Signature							

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** 12:00P M FEB. 2009 MARGARET WILCOX Α. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY 4412 CANNES LA. OLNEY If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 1 □ F Months Days Hours Min. 58 16, Director 218-56-9347 JAN. 1951 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show in than "natural", or items 23a or 28a-f show 1 X Yes 2 □ No Director MONTGOMERY OLNEY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4412 CANNES LA. 20832 U.S.A. Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: þ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, Inc. M. OFFICE MANAGER RESEARCH CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **GUY** MERLIN MARION L. SAWYER ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4412 CANNES LA., OLNEY, MD. MARGARET A. WILCOX/SELF 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-26-2009 CHAMBERS CREMATORY RIVERDALE, MD. 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM.P.A. Chamlung M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** WIDELY METASTATIC BREAST CANCER 8½ YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to for as a consequence off d any, leading to in medic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed and Due to (or as a consequence of): burial Box 68760, physician Physician/Medical the as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 ☐Yes 2 XNo o he 9 Unknown à σ. signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I of Vital Records, þ 1 ☐ Yes 2√☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy page ; performe certificate 1 □ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No this o 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Division 5 Pending investigation 1 X Natural death. 1 🗆 Yes 2 🗌 No filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide e Funeral 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 2 To the I and manner stated. 29b. Signa 29d. Date signed (Month, Day, Year) fure and title of certifier 29c. License number D37236 FEB. 25, 2009 son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of 6410 ROCKLEDGE DR. #506, BETHESDA, MD. 20817 CAROLYN B. HENDRICKS, M.D. 31. Date filed (Month, Day, 32 Registrar's Signature Year) State **FEB 27** Registrar

			_ For	State of Ma		d / Dep	artmer	nt of H	ealth a		ntal Hv	aiene			00001
			State Registrar			Ce	rtifica	e of L	Death				200		08031
Physi	iciai	1	1. Decedent's Name (First, Middle, Las	it)			NE	LA	1)5		Date of De Month	Day	Ye	ear 209	3. Time of Death 1800 PM
/Med Exam			4a. Facility Name (If not institution, give	e street and number)			Τ		Location of		CBRUA		County of I		
y Exam	iirie	'	Johns Hopkins Hos						1timo						
Funera	al		5. Social Security Number 6. S		(In yrs. la	ast birthday) If Unde Months	r 1 Year	If Under 2 Hours		Date of Bir (Month, Da	th ly, Year)	9.	Birthplac	ce (State or Foreign
Directo	or		214-39-1319	M 2□F	15	Yrs.					pril 2	26,19	93		land
and		- 1-	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or L	ocation							10d	. Inside City Limits
Maryl f sho		<u> </u>	Maryland Howar	a	T.Joo	t Fri	ondah	in							1 □Yes 2 🖾 No
r 28a		Director	Maryland Howar 10e. Street and Number	<u>u</u>	WES	C TII	10f. Zi					10g. Citiz	en of Wha	it Country	?
death with the Maryland ims 23a or 28a-f show	-	ᄪ	14138 Rover Mill	Road				2	21794				Unit	ed S	tates
ems ems		Funeral	11. Marital Status	12. Was Decedent B Armed Forces?	ver in U.S	S. 13.	Was Dece	dent of His	spanic Orig n, Mexican,	gin? (Speci Puerto Ri	fy Yes or No can, etc.)	- 1	4. Race - A	American Vhite, etc	
s after	ı	Dy F	1 Never Married 2 Married	1 ∐Yes 2 🖎 N If Yes, Give	0		1 ☐ Yes		Specify:				Specify:		
hours tural	-		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:		16a Dec	edent's Usu	al Occuna	ation			16h Kin	d of Busin		ite
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e file al Hy I othe		Pe P	17. Father's Name (First, Middle, Last)						18. Mother	r's Name (i	First, Middle	Maiden S	Surname)		
should be filed within 72 hours after death with the Marylan and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show aumatic event, it e Medical Experiencement be neaffed at		0	Kirk D. Weiland			1					'Andre				
2 sho n and is m raum			19a. Informant's Name/Relationship (•				Route Numb				,
1 and Health	J	4	Lisa M. Weiland/ 20a. Method of Disposition	Mother	20h Pl					Dad, Dat			ation - Cit		y1and2179
permit. Pages Department of important: If Its any Injury or o			1 ☐ Burial 2 2 Cremation 3 ☐		1	lace of Disp emetery, cre									
nit. Partme ortan	ญ้	ŀ	4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer		Sta				y Inc.						ryland
permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic ev	onc		MIX	Uknes	1	SI	tauff 621 0	er Fu possu	ıneral ımtown	l Home 1 Pike	e P. A e, Fre	deri	ck, M	aryl	and 21702
Physicia			23a. Part I. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	1	the death	n. Do not e	nter the mo	de of dying		cardiac or		rrest,		A	pproximate iterval Between inset and Death
/Medica			resulting in death)	Due to (or as											
TD +		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	consequ	ence of):					~				
eath certificate be executed attending physician and for use as the burial-transit		Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c											
be ex cian a	!	cal E	resulting in death, East	Due to (or as a	a consequ	ience of):									
certificate nding physise as the b			•	d											
nding use at	1	NW.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								2	3d. Date o	f delivery	
sician: The law requires that the death certificate has been signed by the atter rector, page 2 should be detached for u		Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			☐ Ectopic ☐ Other (s						Month		
s that gned t		Dy P	Part II. Other significant conditions of	ontributing to death bu	it not resu	ılting in the	underlying	cause give	en in Part I.		23e. Did 1	obacco us	se contribu	te to the	cause of death?
ne law requires t has been signe ge 2 should be c		ed ed			-						1 🗆	Yes 21	No 3[☐ Probab	ly 4 🗌 Unknown
aw as b		Completed									24a. Was	osv	24b. Wer	re autops	y findings available letion of cause of
The cate h	1	5									perfo	rmed? 2 🔀 No	dea 1 🗆	th? Yes 2	□No
ician certifi ector		g Re	25. Was case referred to medical examiner?	Hospital:				Ot Othe	ar:		Check only o				
ding Physician: The I h. After this certificate ha funeral director, page	- 1	<u> </u>	1 ☐ Yes 2 🔀 No 27, Manner of Death	28a. Date of Inju		ER/Outpati		OA Olino 28c. Injury	4 LI NUI		e 5 ☐ Resi d. Describe		· · · · · ·	(Specify)	
nding th. : Afte		5	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	i, Year)	Injury	M_	Work	? Yes 2 □ N			,,			
I or Attending after death. I Director; Afte		Certification:	3 ☐ Suicide 6 ☐ Could not b		iry - At ho	me, farm, s	treet, factor	y, office		28	f. Location (Street and	i Number o	or Rural F	Route Number,
tal or s afte al Dir		Ser	4 Homicide	building, etc	. (Opecii)	"					City of To	wii, State)			
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.		edical (nysiclan: To the best on miner: On the basis of and manner sta	examina										
To th within To th comp	1	Ze Z	29b. Signature and title of certifier					c. License				29d. Date	signed (A	Aonth, Da	y, Year)
(- MD				RES	-001	0		FEBR	UARY	22	2009
(6)	/		30. Name and address of person who									, _	11.		
			JUSTIN LOCKMAN 31. Date filed (Month, Day, Year)	J THE JOHA	S HOF	KINS	HOSPI	TAL	600 N	J. Wo	Ite Sh	reet t	saltyr	love,1	MD21287
Regi	Stat stra		or. Date filed (Mohth, Day, Tear)		ars Signal		A JAM	1						-	
-3.				17		60	1								

			For State of Maryla 1 - State of Maryla		rtificate of I		Reg	. No. 2009			
	Physicia		Decedent's Name (First, Middle, Last) Hwa W. Wood				2. Date of Death Month February	^{Day} 2, 2009	3. Time of Death 7:21 A M		
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	,	4c. County of Death						
and.			Civista Medical Center		La Pi	ata If Under 24 Hrs.	1 0 D 1 (D) #	Charle			
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F 87 87	s. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,) Nov. 16,	(ear) 9. Birth Cou	place (State or Foreign intry) Wain		
	yland how		Usual Residence of Decedent 10a. State 10b. County 10c. C	City, Town or Loc	cation				10d. Inside City Limits		
	e Mar	5	Maryland Charles				1 □ Yes 2 🗖 No				
	er 28	Directo	10e. Street and Number		10f. Zip Code		100	g. Citizen of What Cou	intry?		
	s 23a	ıral	7515 Cameron Ridge Road		20637			USA			
30	be filed within 72 hours after death with the Maryland and Hyglene. Id other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, I've Medical Exprisive I man be nettiled at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ፟ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 M No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2ሺ No	ispanic Origin? (S) an, Mexican, Puerto Specify:	Decity Yes or No- Dican, etc.)	14. Race - Ameri Black, White, Specify: Ch			
15-0036	72 hour 'natural dical Ex		15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup	during most of worl		b. Kind of Business/Ir	ndustry		
7	ithin ne.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Home	DO NOT use retired Maker	1)		Self			
and	al Hyler I other	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, Ma	niden Surname)			
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Mar	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type. Print) Mei Wieck/ Daughter		•			City or Town, State, Zi	. ,		
<u>6</u>	1 and 2 Health tem 27 other tr				sition (Name of natory or other place			C. Location - City or T			
ē	Pages nent of nt: If i		1 A Burial 2 Li Cremation 3 Li Removal from State 1			:	ch 5, 200	9 Chelten	ham. MD.		
Baitimor	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Signature (1997)	22	2. Name and Addre	ss of Facility H	untt Fune				
			23a. Part 1. Enter the disease, or complications that caused the dea			_			Approximate Interval Between		
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	12	hound	dise	in		Onset and Death		
	/Medical Examiner		resulting in death) Due to (or as a conse	equence of):	3,000						
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	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
Ď,	ificate be executed g physician and as the burial-transit		resulting in death) Last Due to (or as a conse	quence of):							
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ROX	death certi e attending id for use a	M/u	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fe		∃ Ectopic pregnanc			23d. Date of deliv	/ery		
о С	w requires that the death certific been signed by the attending p should be detached for use as	hysician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 9 □ Unknown	y		Month Day Year					
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	n: The lificate har, page		OF Was seen of soud to modical				1 □ Yes 2d	No 1 ☐ Yes	2 🗆 No		
Vital	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? Hospital: 1 □ Inpatient 2	₹ ER/Outpation	ot 3 DOA Oth	or:	th <i>(Check only one)</i>	ce 6 ☐ Other (Spec			
0	ding Physician: The law h. After this certificate has funeral director, page 2 s	n: To	27. Manner of Death 28a. Date of Injury	28b. Time of Injury		y at	28d. Describe how		ny)		
SIOL	tendin eath. or: Aff the fur	catio	2 Accident investigation	Пусту		Yes 2 □ No					
DIVISION	al or Att s after de il Direct ed in by t	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Special County of the suit o	home, farm, stre cify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Rur State)	al Route Number,		
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director. After the completely filled in by the funeral	edical (29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my king the desire of examiner. On the basis of examinent and manner stated.	nowledge, death nation and/or in	h occurred at the til vestigation, in my c	me, date and place pinion, death occu	, and due to the cau rred at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)		
	To th within To th compl	Me	29h. Signature and title of certifier		29c. Licens	e number	290	d. Date signed (Month,	, Day, Year)		
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(and the state of t	00a\ /Time	Print)	4 -1 .	. /4	1007 15	6		
1	16 16		30. Narge and address or person who completed cause or death (10) Year. a. M. Taylour, M.D. 25. 31. Date filed (Month, Day, Year) 32. Registrar's Sign	15 00 /10	in teak	aut Vol. 1.	CONSTRUM	JII) 6 05			
	Sta Registr		FFR 2.6 2009		broket						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-01872 State of Maryland / Department of Health and Mental Hygiene 08036 Patrona Dezlaya 2009 Certificate of Death 1- For State Rea. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ 0339 hrs Zelaya March 6, 2009 Medical Examiner Μ. De Petrona 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Montgomery Rockville Shady Grove Adventist Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 12/27/1930 FEGun Salvador Months Min Days Hours Director 220-33-6637 78 Yrs M 2 XF Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No Kensington s 23a or 28a-f show a Montgomery MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20895 El Salvador 2803 Jennings Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11 Marital Status 12. Was Decedent Ever in U.S must be If Yes, specify Cuban, Mexican, Puerto Rican; etc.) White, etc Armed Forces? 1 Never Married 2 X Married White 2 X No Yes ElSalvadoren If Yes, Give Year 1 X Yes No Specify Widowed 4 Divorced "natural" ≥ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 hant of Health and Mental Harris Own Home If item 27 is marked other than ' her traumatic event, the Medical Homemaker 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Santos Majano Yanez Demetrio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 230 Hobbits Lane Westminster, Md. 21158 M Mario Pablo Zelaya/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 3/10/2009 Silver Spring, Md Gate of Heaven Other Spe. Dona non 5 of Funeral Service Kic PHTTTPdd BokTWALDI FUNERAL SERVICE, P.A. 9241 columbia Blvd.Silver Spring,Md2091 Approximate Interval Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. Death Medical Hypertensive atherosclerotic cardiovascular disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit AMENDED 23a, PII, 2/, perME, g890 4/22/09 Physician/Medical X UNPENDED tending physician a use as the burial -The law requires that the death certificate be Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Dav Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown for 9 Unknown the 8 detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ncate has been signed by page 2 should be detach 1 Yes 2 No 3 Probably 4 V Unknown ð Records, P. Diabetes mellitus Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has performed? death? No 2 ✓ Yes 2 1 🗸 Yes 26. Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical director. Division of Vital Be examiner? Hospital: Other₄ Other DOA Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 this 1 V Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year 28b. Time of Injury After 27. Manner of Death Certification within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 X Natural Yes 2 No Pending 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier PEND March 7, 2009 O.C.M.E.

Registra

Carol Allan, MD

31. Date filed /M

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

2. Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a)

		1 - For State of Maryland / Dep	partment of Health and Mertificate of Death	lental Hygie	ne No. 2009	08037
		Decedent's Name (First, Middle, Last)		2. Date of Death	No.	3. Time of Death
Phys		Mario Humberto Acuna		March 5,	Day Year 2009	2:30 A M
/Me			4b. City, Town, or Location of Death		4c. County of Death	2.30
June 10.		3902 Claxton Place	Bowie		Prince Geo	roels
Funer	al	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthp	lace (State or Foreign
Directo		215-58-9635 ¹ ⊠ M 2□ F 68 Yrs.	Months Days Hours Min.	Month, Day, Ye.	1940 Arge	ntina
ъ.		Usual Residence of Decedent				
arylaı shov	_	10a. State 10b. County 10c. City, Town or L	ocation		1	0d. Inside City Limits
Ba-f	ctc	Maryland Prince George's Bowie				1X∏Yes 2 ☐ No
ith th	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Coun	itry?
ath v s 23a	Funeral	3902 Claxton Place	20715	USA	<u> </u>	
er de Items	nu	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, e	
36 s afte ", or "	N V		1X Yes 2 □ No Specify:		Specify:	
bour tural	pa	3 Widowed 4 Divorced Year or Dates:	Arger		Wh	ite
15 n 72 n 72	Completed	15. Decedent's Education (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of workir DO NOT use retired)	ng Tob.	Kind of Business/Inc	iustry
with iene.		Elementary/Secondary (0-12) College (1-4or 5+) Astr	ophysicist	NA	ASA	
filed Hygother ent,	BeC	17. Father's Name (First, Middle, Last)	<u> </u>	(First, Middle, Maid		
'e, Maryland 21215-0036 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examin or must be recitified at	To B	Manuel Humberto Acuna	Maria Fe	lisa Oliva	a Soaie	
shou and N	-		ing Address (Street and Number or Rura			Code)
Ind 2 alth alth alth artha			Claxton Place Bowi			,
othe sta		20a. Method of Disposition 20b. Place of Disposition	osition (Name of Dematory or other place)	ate 20c.	Location - City or To	wn, State
Page Tent of Int: If		Haz bunar 2 Cronemation 3 Cremoval from State	f the Pines 3/11/	/2009 Be	erlin, MD	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Experiment must be notified at	형		22. Name and Address of Facility $Rob\epsilon$			1 Home
a E E E	ā		16000 Annapolis Roa			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not er shook, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac o	r respiratory arrest,		Approximate
Physicia		Immediate Cause (Final	voltiple myelou	10	1.	Interval Between Onset and Death
/Medica	_	disease or condition resulting in death) a	10111110 Mileton	14	/	Vr. 411103
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8760, cate be executed physician and the burial-transit	dical	d				
ox 6 certific nding p	Mec	IF FEMALE:				
death certific death certific a attending p	an	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	☐ Ectopic pregnancy	<u>.</u>	23d. Date of delive	•
the de	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month	Day Year
eta par 🗖	Ph	Part II. Other significant conditions contributing to death but not resulting in the u	undoubles source situation Death	200 Did to be a se		
Ords, Prequires that seen signed be deta	þ	Tark in Suite Significant Contained in Contained in the Leading in the L	indenying cause given in Part I.		o use contribute to the	
requ bould	eted			1 ☐ Yes	2No 3□ Proba	ably 4 ☐ Unknown
0 0 00	Completed			24a. Was an autopsy	24b. Were autop	sy findings available pletion of cause of
VITAI HE ician; The lav certificate has ector, page 2	S			performed?	death?	2 □ No
VITAI iician: T certificat ector, pa	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death	(Check only one)		
OT VITA Physician; r this certific ral director,	은	1 Inpatient 2 ER/Outpatie			6 ☐ Other (Specify)
ding After funer	ion	↑ Natural 5 Pending (Month, Day, Year) Injury	Work?	8d. Describe how inj	ury occurred	
VISION Attending r death. ector: Afte by the fune	cat	2 Devicide 6 D Could not be	M 1 Tyes 2 No		W	
DIVISION I or Attending after death. I Director: After d in by the fune	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, lactory, office	City or Town, Sta	and Number or Rural ite)	Route Number,
spital ours neral filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place a	and due to the cause	(e) and manner as st	atad
24 h	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurre	ed at the time, date a	nd place, and due to	the cause(s)
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page.	Me	29h Signature and title of certifier	29c. License number	29d. D	Date signed (Month, D	Pay, Year)
- > - 0		& Legouth was	1719028	2	15/2009	7
7		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) a	7	312001	
		Strait E. Selonick, MD 90	o Bestgate Rd.	Hunas	polis, M	ds
S	tate	31. Date filed (Month, Day, Year) 22. Registrar's Signature		·		
Regis	trar	30. Name and address of person who completed cause of death (Item 23a) (Type, Strait E. Selonick, MO 90) 31. Date filed (Month, Day, Year) AR 1 6 2009 ARR 1 6 2009				
DHMH 17 Bey 1	/2001	PIRTUA V				

09-01902 Misha Atkins

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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	1- For State Registrar		Certificate o	f Death		Reg. No.		
Physician/ ledical Examiner	Decedent's Name (First, Middle	,Last)			2. Date of D Month March	Death Day Year 7, 2009	3. Time of Death 0600 hrs	
	4a. Facility Name (if not institution 3412 Ravenwood Aver			4b. City, Town, or Location Baltimore	n of Death	4c. County of	Death	
Funeral Director	5. Social Security Number UNK	6. Sex 7. Age (In yrs. last birthday) 36 Yr	Months Days Ho		Birth (MM/DD/YYYY) 19–1972	9. Birthplace (State or Foreign Country) MD	
any	Usual Residence of Decedent 10a. State 10b. County	110	c. City, Town or Loca	tion			10d. Inside City Limits	
* -	MD	n/a		altimore			1 X Yes 2 No	
th the Maryland 23a or 28a-f sho notified at once.	15 S. Payson Str	eet		10f. Zip Code 21223		10g. Citizen of Wha	: Country?	
fter death wi	11. Marital Status 1 X Never Married 2 Ma 3 Widowed 4 Divo	12. Was Decedent Evarried Armed Forces? 1 Yes 2 Xerced If Yes, Give Year or Dates:	No If	as Decedent of Hispanic C Yes, specify Cuban, Mexic Yes 2 X No spec	an, Puerto Rican, etc.)		American Indian, Black, etc. African-American	
6 72 hours an "natur al Exami	15. Decedent's Education (Special Elementary/Secondary (0-12)	College (1-4 or 5+)	during r	nt's Usual Occupation (Gir nost of working life. DO NO AShier		16b. Kind of Busin		
21215-0036 Juld-be filed within 72 hours a Mental Hygiene marked otter than "natural c event, the Medical Examin fo Be Completed by	8th 17. Father's Name (First, Middle, Michael Standfiel	,			ner's Name (First, Midd Dories At	le, Maiden Surname)	: 5	
Baltimore, MD 21215-003 permit. Pages 1 and 2 should-be filed within Department of Health and Mental Hygiène. Important: If item 27 is marked other thinjury or other traumatic event, the Med Trium or other traumatic event, the Med To Be Comp	19a. Informant's Name/Relationsh Dories Atkins/ M	nip (Type, Print)		ng Address (Street and N Boone Street, I	lumber or Rural Route	Number, City or Town,	State, Zip Code)	
ore, MD ss 1 and 2 sho of Health and If item 27 is her traumati	20a. Method of Disposition 1 X Burial 2 Cremation	·	20b. Place of Dispo	sition (Name of cemetery,			ity or Town, State	
Baltimore, permit. Pages 1 an Department of He Important: If ite	Donation 5 Other Sp 21 Ignature of Funeral Service	ecify:		Name and Address of Fac			e, MD of talto. Co.	
on ಔՃ ∄ ∄ Physician	23a. Part I. Enter the disease, or o			200 LibertyRoac the mode of dying, such a	<u> </u>			
/Medical kaminer	failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)	a. Methadone Due to (or as a consequ		ion			Between Onset and Death	
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~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	IF FEMALE: 23b. Was decedent pregnant in th past 12 months? 1 Yes 2 No 9 ✓ Unk	4 Pregnant at tin	2 _ F	etal death 3 Ecto	opic pregnancy	23d. Date of delivery Month Day Y		
P.O. es that the igned by be detach	Part II. Other significant conditi	ons contributing to death b	ut not resulting in the	underlying cause given in		23e. Did tobacco use contribute to the cause of de 1 Yes 2 No 3 Probably 4 VIII		
of Vital Records, ng Physician: The law require ther this certificate has been signeral director, page 2 should b. n: To Be Completed						utopsy pri	ere autopsy findings available or to completion of cause of ath?	
tal Rection: The Locatificate Lector, page	25. Was case referred to medical			26 Diago of Doc	1 ✓ Yeath (Check only one)	es 2 No 1	Yes 2 No	
Vital F ysician: his certifi director, o Be C	examiner?	Hospital: 1 Inpatient	2 🗸 ER/Outpatier	Othor		Residence 6	Other:	
nd of Virthing Physich. The After this efuneral direction: To I	1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pend	28a. Date of Injury (Month, Day, Year	28b. Time of	Injury 28c. Injury at W	ork? 28d. Descri	be how injury occurred		
Division o spital or Attending rours after death. neral Director: Aft filled in by the fune Certification:	2 Accident Inves 3 Suicide 6 X Could	tigation FG 3///G a not be 28e. Place of Injur	y - At home, farm, stre	0 am] eet, factory, office building	, etc. 28f. Locatio	on (Street and Number n, State) 34 L2 R	or Rural Route Number, City avenwood Ave	
the Ho hin 24 h the Fu npletely	29a. Certifier 1 Certifying Ph	ysician: To the best of my k	nowledge, death occu		place, and due to the o			
To with To com	29b. Signature and title of certifie	and manner stated.		29c. License numb			(Month, Day, Year)	
	30. Name and address of person Ana Rubio MD. Ass	who completed cause of dea istant Medical Examir		Street, Baltimore, N	ID 21201	_		
State Registrar	1 () 0	009 32/Registrar's	B An	KN				

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Year Hichard Burgess 08 14 AM March 8 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sohns Hopkins Bayview Medical Center Baltimore If Under 1 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. 1⊠M 2□ F Months Days Hours 219-40-268 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location d other than "natural", or items 23a or 28a-f show event, it a fredical Even invernment by notified at 10d. Inside City Limits Director 1 Yes 2 No 566160 death with the 10e. Street and Number 10g. Citizen of What Country? USA Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritai Status filed within 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 MLNo 2 Specify Specify: BLACK 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) AUTO NIC and Mental Hygie is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be innent of Health and Mental ဂ္ဂ 19a. Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trauonce. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Fineral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Failure hespiratory hour /Medical Due to (or as a consequence of): Examiner Cerebellar 2 weeks Sequentially list conditions, the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Due to (of as a consequence of) certificate be execute Shock and Box 68760, the attending physician Physician/Medical the nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Dav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 ☐ No of Vital 1 □Yes 2 Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division To the Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number LES -000 March &, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anjail Sharrief 4940 Eastern Avenue Baltimore, N-D am 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State Registrar MAR 1 6 2009

09-01842 Delores Bailey	Please Type or Print in Black Indelible Ink. Ensure All Copie State of Maryland / Department of Health and Mental H - For State Certificate of Death	es Are Legible. ygiene 2009 0804 (
<u>_</u>	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year 2317 hrs
Physician/ Medical Examiner	Dalares F Bailer	March 4, 2009 2317113
	4a. Facility Name (if not institution, give street and number) 1621 Village Green Drive 4b. City, Town, or Location of Deat Hyattsville	Prince George's
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr Months Days Hours Mi	Foreign Mas Na October 1
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
* . l	MD Frince Georges Landover	1 Yes 2 No
7 3817 72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ral Examiner must be notified at once. leted by Funeral Director	10e. Street and Number	USA
th the notifi	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (14. Marital Status) 15. Was Decedent of Hispanic Origin? (16. Was Decedent of Hispanic Origin? (17. Marital Status)	Specify Yes or No- 14. Race - American Indian, Black, White, etc,
r death with or items 23 must be no	1 Never Married 2 Married Armed Forces? Armed Forces? If Yes, specify Cuban, Mexican, Puer	Plack
	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:	Specify: Spe
atural"	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use r	etired)
136 hin 72 hours afte than "natural", edical Examiner	Elementary/Secondary (0-12) College (1-4 or 5+) Procurement Ana	list U.S. Government
15-0036 filed within 72 hours In Hygiene. et other than "natur i, the Medical Exam e Completed	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	me (First, Middle, Maiden Surname)
## 를 불 등 등 a	William Read	een Greer
Baltimore, MD 21215 permit, Pages I and 2 should be fill Department of Health and Mental H Important: If iten 27 is marked injury or other traumatic event, t	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Street and Number of	or Rural Route Number, City or Town, State, Zip Code)
MD A 2 shouth and ith and in 27 is aumatis	Collins L. Bailey-husbard 1621 VIIIage Gr. 200. Place of Disposition (Name of Jemetry)	Date 20c. Location - City or Town, State
or Health If item 2 Isher traus	20a. Method of Disposition 20b. Place of Disposition (Name Described), crematory or other place)	lizing Landover, MD
Baltimore, permit, Pages I at Department of Hes Important: If ite injury or other tr	4 Donation 5 Other Specify: Itamony Cemetery 3	13/09 Landover, IVI)
Baltimo permit, Pag Department Important: injury or or	21-Signature of Funeral Service Licensee 22/Name and Address of Hacility 10220 Grul-Grd	Pal Tasi 0 MD 20794
	The standard of dying, such as cardia	ac or respiratory arrest, shock, or heart Approximate Interval Between Onset and
Physician Wedical	failure. List only one cause or each line. Acting Bronchitts Complicating A	therosclerotic Death
aminer	Immediate Cause (Final disease or condition resulting in death) a. Cardiovascular Disease Due to (or as a consequence of):	
	Sequentially list conditions, b.	
	Due to (or as a consequence of).	
outed to not not not not not not not not not	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
e execut cian and rial - tra		23d. Date of delivery
Box 68760, sight death certificate be the attending physic for use as the but	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pr	Voor Voor
certif	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	
;, P.O. Box ires that the death ires signed by the atte	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.	23e. Did tobacco use contribute to the cause of death?
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S, P		24a. Was an 24b. Were autopsy findings available prior to completion of cause of
cords, law requir shas been s	26.Place of Death (C	performed? death?
Reco	26.Place of Death (C	Tes 2 No 1 Tes
Vital Rec	25. Was case referred to medical	Jursing Home 5 Residence 6 ✔ Other: Scene
Physic r this	Q 1 ✓ Yes 2 No	28d. Describe how injury occurred
n of ding Ph		
SiO Atten r deatl ector by the	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division of Vital Records, tal or Attending Physician: The law require as after death. "al Director: After this certificate has been si led in by the funeral director, page 2 should be in the funeral director, page 2.	1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
		e, and due to the cause(s) and manner as stated. Irred at the time, date and place, and due to the cause(s)
To the within 2 To the complet	and mariner states.	29d. Date signed (Month, Day, Year)
	29b. Signature and title of certifier O.C.M.E.	March 5, 2009
	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201
	Carol Alian, Nie	
Sta Regist	ate 31. Date lived (World) 6. 2000	

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death BARNETT Month **Physician** 2009 642 M NNIE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Anundel Hospice of the Chesapeake Linthiam 8. Date of Birth (Month, Day, Yo 10-24-1931 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Min. 1 □ M 2 1 F Days Hours 248-56-7223 77 Director SC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if the Machina I Examina I must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 □ Yes 2 🕅 No MD Prince George Laurei 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9010 Briancroft Lane # 415 20708 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 DiNo Specify: à African-American 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Elementary School Teacher Public School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Early Miller Johnsie Spratt ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Belinda Barnette Strayhorn/ Daughter 110 Bunker Hill Lane, Odenton, MD 21113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State angrum Branch Church 3-18-09 4 ☐ Donation 5 ☐ Other (Specify) York, South Carolina 21 Sanature of Fuperal Service Licensee 22. Name and Address of Facility Wile Funeral Hone P.A. of Barto. Co. 9200 LibertyRoad, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): and burial-tra resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical as t attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed certificate 2 🗆 No 1∐Yes 2 🖳 🗚 🗸 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: DICE 1 Inpatient 2 ER/Outpatient 3 DOA 6 Nother Spacify) H Certification: To 4 \sum Nursing Home this 5 Residence within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral or 27. Manner of Death 1 Natural Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? HUUSE 28d. Describe how injury occurred 5 Pending investigation 1 □Yes 2 □No 2 Accident 3 Suicide 6 Could not be determined

The law requires that the death certificate be executed Box 68760, P.O. I of Vital Records, To the Hospital or Attending Physician: Division

Maryland 21215-0036

Baltimore,

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

Registrar

Medical

31. Date filed (Month, Day, Year)

Name and address of person who co

2. Registrar's Sigr

leted cause of death (Item 23a) (Type, Prin

State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MARCH Dav BATES **Physician** EDMONIA 3:30 A-M 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 405 Pit SECOURS SON Baltimore n/a Birthplace (State or Foreign Country) If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. Hours 1 □ M 2 💢 F Months 7-14-1921 Director 212-20-9450 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Completed by Funeral Director Baltimore n/a 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 USA 5400 Fairlawn Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify: If Yes, Give Year or Dates specify: African-American 3 ₩idowed 4 Divorced natural 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Jewish Conv. Hane Nursing Assistant 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental I Susie Dennis Herman Wright ဂ္ other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health at Important: If Item 27 Is any injury or other trauonce. 5400 Fairlawn Avenue, Baltimore, MD 21215 H. Donald Bates/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 11☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 3-18-09 Woodlawn, MD 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 21. Signature of Funeral Service Licensee 9200 Liberty Road, Randallstown, MD 21133 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DIAC Physician /Medical EN SIVE CARDIOVASCULAR DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner KIDNEY or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit RONIC Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unktlown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was en autopsy performed? Yes 2 No 2 No 1 □Yes 1 TYes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 -No 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No death. 2 Accident after deat 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Hospital Descritifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0030353 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) BON SECOURS 32. Registrar's 31. Date filed (Month, Day, Year) State Registrar

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Box 68760.

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 25 per dr., g889,03/16/09dhb Reg. No. 2 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Beverungen **Physician** Kuth 5:19 2009 /Medical March 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore** Towson If Under 1 Year 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Min 1 □ M 2 🔀 F Months Days Hours Sept 19. Director 213-28-8799 1931 Illinois Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State nt of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Eventine must be notified at Director 1 ☐ Yes 2√☐ No Md. Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12101 Tullamore Court #206 21093 Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: ģ Specify: White 3 ₩ Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic evone. Vetrhus Bjornson Kari Ben 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Jean Beverungen/ Daughter 7901 Oakleigh Rd. Baltimore, Md. 21234 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 NOther (Specifintonbment Dulaney Valley Mem. i3-13-09 Timonium, Md. 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Fundal S rvice Licens 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one ca Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 ☐ No 1 □ Yes 2 Physician: the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 1 Dopatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural
2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 3-10-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21093 TULLAMORE Rd Imonium 12221 egistrar's Signatur 31. Date filed (Month, Day, Year) 32 State

DHMH 17 Rev 1/2001

Registrar

MAR 1 6 2009

			1 - For State Registrar	State of Marylan		artment of F rtificate of I			giene Reg. No. 20	9 08045		
	Physici /Medic		Decedent's Name (First, Middle, Last) JANCE	BRIAN		BLOOM		2. Date of Dea Month MARCH	ath	3. Time of Death 09 4:55 P M		
	Examin		4a. Facility Name (If not institution, give s	treet and number)	T 0TD	4b. City, Town, or	r Location of Death	4c. County of Death				
-	Funeral		HOSPICE OF BALTING 5. Social Security Number 6. Sex	7. Age (In yrs.		TOWSON If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	BALTIM			
	Director		218-66-1499	M 2□ F 54	Yrs.	Months Days	Hours Min.	12/09/	1954	Birthplace (State or Foreign Country)		
	yland st		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits		
	ne Mar 8a-fsl	Director	MD N/A		ВА	LTIMORE				1 X Yes 2 □ No		
	with the		10e. Street and Number 2403 EAST FAIRMOU	INT AVENUE		10f. Zip Code 212	22.4		10g. Citizen of Wha	•		
	ems 2:	Funeral		Was Decedent Ever in U. Armed Forces?	S. 13. \		. 24 ispanic Origin? (Span, M <i>e</i> xican, Puerto	ecify Yes or No-	US. 14. Race -	American Indian,		
5-0036	172 hours after death with the Maryland "natural", or items 23a or 28a-f show dical Evar. it at must be notified at	þ	1 💢 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates:		1 ⊡Yes 2 🛣 No	Specify:	Hican, etc.)	Specify:	WHITE		
Ò	n 72 h "natu	olete	15. Decedent's Educi (Specify only highest grade	ation co <i>mpleted)</i>	16a. Dece	dent's Usual Occup	ation during most of worki	ng	16b. Kind of Busin	ess/Industry		
212	be filed within 72 hc ital Hygiene. id other than "natul event, the Midical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		MPUTER PR			COMP	UTER		
⊆	ild be filed lental Hygi ked other ic event, I	Be	17. Father's Name (First, Middle, Last)	DI CO	.,				Maiden Surname)			
Š	ges 1 and 2 should be tt of Health and Menta If item 27 is marked or or other traumatic ev	ည	SAMUEL 19a. Informant's Name/Relationship (Typ	BL00		a Address (Street	ANNE and Number or Rura			SBERG		
Ĕ	and 2 stealth and 2 stealth and 27 is her tract		TAMARA BLOOM / SIS	·			ILLE RD.,					
<u>e</u>	Pages 1 ar nent of Hea ant: If item 3 ury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	Charles Charles C	emetery, cren	sition (Name of natory or other place	e) !	ate	20c. Location - Cit			
Бант	permit. Page Department of Important: If any injury or once.		Donation 5 ☐ Other (Specify) 3. Sign ture of Juneral Service Liganore	CAR		KEMATION Name and Addres	INC 03/12		HAMPSTE			
ñ	Per Pep any		Watul Mc	Kemer	1				ISON & BRO PIKESVILI	LE, MD 21208		
			23a. Part 1. Enter the disease, or complies shock, or heart failure. List only one immediate Cause (Final	ations that caused the deat cause on each line.	. Do not ente		g, such as cardiac o	or respiratory an	rest,	Approximate Interval Between Onset and Death,		
1	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequ	uence of):	CANC	er			year		
	Examiner		Sequentially list conditions b.									
by.	nsit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a consequ	uence of):							
ָ כ	an and	Exa	that initiated events c. resulting in death) Last	Due to (or as a consequ	uence of):				-			
0/00	icate be executed physician and the burial-transit	edical	d.									
o you	attending for use as	Physician/Me	in the past 12 months? 1 □Yes 2 □ No	ic. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of d	I death 3 □	Ectopic pregnancy	,		23d. Date of Month	f delivery Day Year		
ב ב	nat the ed by th detach	Phys	9 ☐ Unknown Part II. Other significant conditions conti		ulting in the up	dorbing serves ship	e in Dani i	22a Did ta	haaa			
, 200 000 000 000 000 000 000 000 000 000	w requires that the or been signed by the should be detached	ted by		build to death but not lest	Tung in the Cit	oenying cause give	en in Faiti.			te to the cause of death? Probably 4 [] Unknown		
ב בייייייייייייייייייייייייייייייייייי	nysician: The law his certificate has L I director, page 2 sl	Completed			_	<u> </u>		24a. Was a autops perfori	sy prior med? deat	e autopsy findings available to completion of cause of h? Yes 2 □ No		
5	sician certifi irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Ho	espital:		Othe	26. Place of Death	(Check only on	ne)			
5	aing rny h. After this funeral d	n: To	27. Manner of Death	1 Inpatient 2 28a. Date of Injury (Month, Day, Year)	28b. Time of	28c. Injury Work	4 L Nursing Hor		ence 6 Other (Specify) Japace		
5	tendir leath. tor: Af the fur	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		Injury	M 1 🗆 Y	? ∕es 2□No					
	a after o	Certification:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office	2	28f. Location (Si City or Town	treet and Number o n, State)	r Rural Route Number,		
7	vicine rospital of Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical (29a. Certifier 1 ☐ Certifying Physic (Check only one) 2 ☐ Medical Examine	cian: To the best of my knower: On the basis of examination and manner stated.	wledge, death tion and/or inv	occurred at the time restigation, in my op	ne, date and place, a pinion, death occurre	and due to the ded at the time, d	cause(s) and manne late and place, and	er as stated. due to the cause(s)		
1	withi To th	Ž	29b. Signature and title of certifier	Maly.	cos	29c. License			29d. Date signed (M			
,			30. Name and address of person who com	pleted cause of death (Item	A /	-Char	les St.	Ball	o. und	2,2009		
	Stat Registra		31. Date filed (Month, Day, Year) MAR 1 6 20	32. Registrar's Signat	ture	ares			<u> </u>	/		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year **Physician** PM BLUM KATHERINE 17:00 M. MARCH 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CENTER 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Sept 12, 9. Birthplace (State or Foreign **Funeral** Year) 1 □ M 2 🕅 F Months Days Hours Min. Maryland 64 1944 Director 219-40-9040 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show traumatic event, the Medical Examiner must be notified at Director 1 ☐Yes 2 No 28a-f MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 21222 23a 403 Westfield Road USA Funeral items ; 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ö 1 ☐Yes 2K No Specify. white Specify: þ 3 X Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic. Elementary/Secondary (0-12) College (1-4or 5+) 12 clerical restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel Leo Bruzdzinski Anna C. Sierakowski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Blum/son 1714 Wycliffe Avenue Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signatur, of Formal Services icenses Wade, 1) rector State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, cheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** FAILURE MULTIPLE ORGAN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner INFECTIOUS IROSEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. I the o 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown been signed by should be detacl Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 🗆 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 ☐ Yes 2 No After this c funeral dire 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural I hours after death. uneral Director: Aft ely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) anur RES-DOC , 2009 MARCH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMES MD 4940 EASTERN AVENUE BALTIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 6 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Marian Frances Cocchiaro 12:30P 03-07-2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Heritage Harbour Nursing Home Annapolis Anne Arunde1 If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Min. Months 1 □ M **X**X F Hours Director 89 12-08-1919 577-12-7833 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits show 10b. County and 2 should be filed within 72 hours after death with the Maryla leath and Mental Hygiene.
To Is marked other than "natural", or items 23a or 28a-f show the traumate event, the Medical Examiner musit be notified at her traumate event, the Medical Examiner musits be notified as Yes 2 □ No Director Maryland Prince George Bladensburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5405 Tilden Road 20710 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify by. Specify: 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Budget Analyst **GSA** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Geddies Ruth Burgess 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any Injury or other trau once. 4946 West End Avenue, Shady Side, Maryland 20764 of Disposition (Name of Date 20c. Location - City or Town, State Carmela Carrick/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery 3-13-2009 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (Dromes **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner MED-Sequentially list conditions, it any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Physician: The law requires that the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 25 No 9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy of Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 🗷 🛶 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 autopsy 2 **M**∕No 1∐ Yes 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be 1 Yes 2 Hospital: 1 ☐ Inpatient Other: 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 2 Accident 5 Pending investigation after death. 1 Yes 2 □ No the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) l in by 4 Homicide

and title of contin

Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

D0040514

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

1667 Crofton Center #1 Crofton, MD 21114 Mirza Nussairee, M.D.

State Registrar

Medical

31. Date filed (Month, Day, Year) MAR 1 6 2009



24 hours a Funeral I the Hospital

within 2

29a. Certifier

29b. Signati

(Check only one)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Colville 600 PM 2009 March 00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins N/A Bayview Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Months 1 □ M 2 😿 F Director 215-40-5071 65 June 3,1943 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be motified at Baltimore Dunda1k Maryland Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 United States 241 Saint Helena Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White "natural", Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than 'any injury or other traumatic event. In Me Elementary/Secondary (0-12) College (1-4or 5+) Contee Gravel Co. Security Guard 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ca11 Virginia Edgar Ray Magee, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11 Township Road Dundalk, Maryland 21222 19a. Informant's Name/Relationship (Type. Print) (Friend) Nancy Clayton 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State oudon Park Cemetery 3/11/2009 Baltimore, Maryland 4 □ Dopation 6 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 21222 7922 Wise Ave. 23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Severe **Physician** Metabolic 12 hours disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner obstructive Chonic pulmonary disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last years Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Completed 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2/**Z**No 1 ☐ Yes 2 **□**/No 1 🗆 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 □ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Res-000 March 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 4940 Nicole Edmond MD Eastern Ave 31. Date filed (Month, Day, Year, 32. Registrar's State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 08049 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Clark Lucy F. March 6, 2009 /Medical 9:10 p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Futurecare Cherrywood Reisterstown Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2√ F Min 216-36-9397 Yrs. Director 68 1940 16, Georgia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits event, the Medical Examiner must be notified at Director Beaufort 1 Yes 2X No SC Beaufort filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 54 Telfair Drive 23a 29907 U.S.A. Funeral items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 ō 1 ☐ Yes 2x No Specify. ð Specify: 3 ☐ Widowed 4 ☑ Divorced "natural" Black Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd 2 should be filed within 7 alth and Mental Hygiene.
27 Is marked other than "n r traumatic event, In a Medi Elementary/Secondary (0-12) College (1-4or 5+) 4 yrs Business Administrator City of Baltimore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nellie Pearl Few မ Moses Cobb 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f and 2 s Health ar permit. Pages 1 and Department of Health Important: If item 27 any injury or other troone. 29907 Lawrence C. Clark, Son 54 Telfair Drive Beaufort, SCJr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 3/11/09 4 ☐ Donation 5 ☐ Other (Specify) Pikesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Se her Eline Funeral Home Reisterstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician usana disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physiclan: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ģ in the past 12 months? Month Day Year 5 ☐ Other (specify) the 1 ☐ Yes 2 No detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate perform 1 ☐ Yes 2 DING 2 □ No 1 □ Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 No Other: 4 ☐ Hursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Defertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 9768 3 1 Mille 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Main Street Sinte Rentessous mond 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 16 2009 Registra

State of Maryland / Department of Health and Mental Hygiene 08050 For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Conroy 2009 6:16 p March 7, Marguerite /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Randallstown 9216 Allenswood Road Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🖸 F Yrs. August 7,1916 PA Director 92 214-44-4448 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f shov 1 ☐ Yes 2x No Director MD Baltimore Randallstown 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 9216 Allenswood Road permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a any injury or other traumatic event, Its Medical Examine mutal once. 21133 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ò 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Department Stores Retail Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Strawser Lula Brown Guy ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9216 Allenswood Road Joseph Conroy Husband Randallstown, MD Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/12/09 4 Donation 5 Dother (Specify) Garrison Forest Vet Owings Mills, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 11824 Reisterstown Road le Eline Funeral Home Reisterstown, MD 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 00050 **Physician** disease or condition resulting in death) RNO /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or as a consequence of). 0 Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☑ No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performe 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No Director After this certification by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No M 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funeral C the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person

000 31. Date filed (Month, Day, Year)

who cop

pleted cause of death (Item 23a) (Type, Print)

09-02010 Lisa Callaway

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 08051 1- For State Certificate of Death Registrar 2. Date of Death I. Decedent's Name (First, Middle,Last Physician/ Lisa Callaway March 11, 2009 0932 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death n/a Johns Hopkins Hospital **Baltimore** If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) $^{5.\ \text{Social Security Number}}_{212\ 82\ 1685}$ 6. Sex **Funeral** Foreign Months Days Hours Country MD Director 48 Dec. 14,1960 M 2 X F Usual Residence of Decedent 10d. Inside City Limits any. 10c. City, Town or Location 10a. State 10b. County MD n/a Baltimore 1 X Yes 2 No 28a-f show with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3123 Cliftmont Ave. 21213 USA 238 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. death v 1 X Never Married 2 Married 2 X No Yes 0 If Yes Give Yea Specify: black 4 Divorced Yes 2 X No specify: "natural". ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) 2 College (1-4 or 5+ Elementary/Secondary (0-12) 72 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If item 27 is marked other than "injury or other traumatic event, the Medical. 21215-0036 type-setter Balto.Sun Paper 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Franklin Callaway, Sr. Estelle Lawson Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Franklin Callaway / brother Baltimore, MD 3208 Elmora Ave. Balto, Md. 21213 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Trinity Cemetery Mar.17,2009 Balto, Md. Other Specify 22. Name and Address of Facility Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto.Md. nature of Funeral Service License 23a. Part I. Enter the disease, or complications that caused be leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. Medical Death Narcotic (morphine) intoxication and cocaine use Immediate Cause (Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and Physician/Medical 23a, PII, 27, 28a-f, perME, g889 3/20/09 TT AMENDED X UNPENDED the attending physician led for use as the burial Box 68760, 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day Live birth Fetal death 2 Pregnant at time of death 5 Other (Specify) Yes 2 No 9 ✔ Unknown a Unknown signed by the detacher 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. à Yes 2 No 3 Probably 4 ✔ Unknown End-stage renal disease, hepatitis C, & endocarditis Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? Yes 2 ✔ No Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medica Division of Vital Be Other₄ examiner? Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 After this ٩ 1 Yes 28c. Injury at Work? 28a. Date of Injury (Month, Day, Yea 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: Natural Yes 2 X No Pending the Fd 3/11/09 Fd 8:45 Director: an 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3123 Cliftmont Ave Baltimore, MD in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be Suicide house Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. March 12, 2009 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. 31. Date filed (Month, Day, Year 2. Registrar's Signature State ankers Registrar

ORIGINAL

		For State Registrar		partment of Health and t ertificate of Death	vientai mygie Reg.	/	08052				
Physic		Decedent's Name (First, Middle, Last)	CARTER		2. Date of Death Month	Day Year 2	3. Time of Death				
/Med Exam Funera	iner	4a. Facility Name (If not institution, give stands and Seconds Hospies) 5. Social Security Number 6. Sex	reet and number)	4b. City, Town, or Location of Death 2000 West Barring (v) If Under 1 Year If Under 24 Hrs.	o RES+.	4c. County of Death	lace (State or Foreign				
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je 22 2	by Funeral			3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 □Yes 2 ☑ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - America Black, White, e Specify: bla	etc.				
vithin 72 hours afficiene. Than "natural", or the modern of the modern o	Completed	15. Decedent's Educ (Specify only highest grade	Completed) (Gi life College (1-4or 5+)	cedent's Usual Occupation ve kind of work done during most of wor e. DO NOT use retired) Sing aide	16t	b. Kind of Business/Ind	·				
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and 2 should and 2 should eaith and Mer n 27 is marke her traumatic	2	19a Informant's Name/Relationship (Type Carolyn Dixon/care	·	ailing Address (Street and Number or Ru 4 St. Dunstans Road			,				
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Departi. Imports eny inje	ouce.	21. Signature of Funeral Service icense	well	.22. Name and Address of Facility State Anatomy Board Baltimore, MD 2120)1						
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68760, ifficate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): A LUSCOSULE COCCOVASCULOR OF SECOND Due to (or as a consequence of): Due to (or as a consequence of): d.									
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DIVISION OF I or Attending Phy after death. Director: After this d in by the funeral d	ation:	27. Manner of Death 1 ☐ Hatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time Injur		28d. Describe how i	injury occurred					
DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:		28e. Place of Injury - At home, farm, building, etc. (Specify)		City or Town, S						
he Hosp in 24 hou he Funei ipletely fil	edical			eath occurred at the time, date and place r investigation, in my opinion, death occu	irred at the time, date	e and place, and due to	the cause(s)				
To t With To t	Z	29b. Signature and title of certifier	Euls mo	29c. License number		Date signed (Month, I					
			143 2000	DO03473 West Battim	nore Str	ect, Bal	limae Mo				
S Regis	state	31. Date filed (Month, Day, Year)	31. Registrar's Signature	arkal		,					

09-01802	
Mamadou Diallo	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		Registrar	Certificate of D	Death		Reg.	No. 200	9 0805
Physicia ledical Exami		Decedent's Name (First, Middle,Last) Mamadou Aliou Diallo			N	Date of Death Month Elarch 3, 20	Day Year	3. Time of Death 1731 hrs
		4a. Facility Name (if not institution, give street and number) Johns Hopkins Bayview Medical Center		City, Town, or Loc Baltimore			4c. County of Death	
Funeral Director		none 1XM 2F	· · · · ·		f Under 24Hrs. 8. Hours Min.	Date of Birth	(MM/DD/YYYY) 9. Birth Foreign	nplace (State or Republic ^{ntry)} Guinea
d 10w any e.		Usual Residence of Decedent 10a. State 10b. County 10c MD	c. City, Town or Location Baltin					10d. Inside City Limits 1 XYes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number		0f. Zip Code		10g	. Citizen of What Coun	
ith the Maryland 23a or 28a-f sho notified at once		2904 Brighton St.		2121			Rep. of G	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	by Funeral	11. Marital Status 1 Never Married 2 Married 2 Married Armed Forces? 3 Widowed 4 Divorced If yes 2 Married Forces? 1 Yes Give Year or Dates:	No If Yes,	specify Cuban, Me es 2 ^X No s _k	<u> </u>	an, etc.)	Specify:	ack
2 hours	eted	15. Decedent's Education (Specify only highest grade complet Elementary/Secondary (0-12) College (1-4 or 5+)		Usual Occupation of working life. DC	(Give kind of work) NOT use retired)	done 1	6b. Kind of Business/In	dustry
3036 Within 7 iene. Ier than	ompleted	12	Та	ilor			Clothin	9 .
imore, MD 21215-0036 Pages I and 2 should be filed within 72 nent of Health and Mental Hygiene. lant: If item 27 is marked other than 'or other tranmatic event, the Medical	Be C	17. Father's Name (First, Middle, Last) Boubacar Diallo		18.1	Mother's Name (Fir Kadja		iden Surname) Diallo	
D 21 Should Und Mer is mar	户	19a. Informant's Name/Relationship (Type, Print)					er, City or Town, State,	
e, MD I and 2 sho Health and item 27 is			20b. Place of Dispositio	n (Name of cemete			Bowie, I	
Baltimore, permit Pages I are Department of Hee Important: If ite injury or other tr		1 XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	washingto		. 3/13	3/09	Suitland	, MD
Baltimore, MD 21215-003 permit Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med		21. Signature of Funeral Service Licensee		ne and Address of I	Facility Uni	versa	l Mortua:	ry Inc.
Physician		23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	death. Do not enter the	Menned mode of dying, suc	th as cardiac or res	piratory arres	shington, l t, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a Cerebral at						Death
J		Sequentially list conditions, b. Acquired In	mmune defic	iency Syı	ndrome (A	AIDS)		
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	nce of):					
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Box 68760, e death certificate be the attending physicied for use as the buried for use	sician	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown 2 Unknown 2 Unknown 3 Unk	2 Fetal	death 3 E	Ectopic pregnancy		23d. Date of delivery Month D	ay Year
that the de ned by the detached i	된	Part II. Other significant conditions contributing to death but	t not resulting in the und	erlying cause giver	n in Part I.	23e. Did toba	acco use contribute to t	ne cause of death?
S, P.O uires that t n signed by	ed by		_				2 No 3 Proba	
Division of Vital Records, P.O. Box 68 Hospital or Attending Physician: The law requires that the death certif 24 hours after death. Fineral Director: After this certificate has been signed by the attending tely filled in by the funeral director, page 2 should be detached for use as	Completed					24a. Was an autopsy perform	prior to co ed? death?	opsy findings available ompletion of cause of 2 No
of Vital ng Physician: After this certif nneral director,	8	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient	2 ER/Outpatient 3	Oth	Death (Check only ler Nursing Ho		esidence 6 Other:	
ing Phy After th	n: To	27. Manner of Death 28a. Date of Injury	28b. Time of Injur	ry 28c. Injury at	t Work? 28d		w injury occurred	
Division fal or Attendi rs after death al Director: A led in by the fu	catic	1 X Natural 5 Pending 2 Accident Investigation	- At home, farm, street, f	1 Yes		Location (Str	eet and Number or Rur	al Poute Number City
Divisior Hospital or Attent 24 hours after death Funeral Director:	Certification:	Suicide 6 Could not be determined (Specify)	The Home, farm, on oot, f	actory, omeo bend	201	or Town, Sta		ar reado rembor, ony
To the Hosp within 24 hc To the Fun completely:	edical	29a. Certifier 1 Certifying Physician: To the best of my knoone) 2 Medical Examiner: On the basis of examinar and manner stated.	-					
2	ΣÍ	29b. Signature and title of certifier	,	29c. License nu O.C.M.E			29d. Date signed <i>(Mon</i> March 4, 2009	th, Day, Year)
Danit.	-	30. Name and address of person who completed cause of death	(Item 23a)	J. U. U. IVI. E			IVIATOT 4, 2009	
Γ		Patricia Aronica-Pollak MD. Assistant Medi	ical Examiner 1	11 Penn Stree	et, Baltimore, N	/ID 21201		
Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Si	ignature					

ORIGINAL

09-01914 Reginald Davis

Physic Medical Exam

Davis		St	oe or Print in B ate of Maryland	I / Departm	ent of	Health ar			gibl		09 080
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hysician/ Examine	r	1. Decedent's Name (First, Middl Reginald	Davi					2. Date of De Month March 6,		Year	3. Time of Death 2359 hrs
	ľ	4a. Facility Name (if not institutio Prince George's Hosp	-	r)	- 4	b. City, Town, o	Location of Death		1	County of De Prince Geor	
uneral : rector		5. Social Security Number 577–80–2338	6. Sex 7. A	ige (In yrs. last bir 49	rthday) Yrs.	If Under 1 Ye		8. Date of B	irth(MM	/DD/YYYY) 9. For	Birthplace (State or reign Washingto
any	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Locati	on					10d. Inside City Limits
≩		District of Co	lumbia	Washi	neto	n					1 X Yes 2 No
a fa	} -	10e. Street and Number	20110 20	, wabiti	ing co.	10f. Zip Code			10g. Cit	izen of What C	ountry?
23a or 28a-f sho notified at once		3516 B Street S	SE			,	20019			ted sta	•
or items 23	2	11. Marital Status 1 X Never Married 2 Ma	12. Was Deceder				spanic Origin? (Sp n, Mexican, Puerto		0-	14. Race - An White, etc	nerican Indian, Black,
rial", or niner mu			1 Yes	2 X No	1	Yes 2 X No	specify:			Specify: BI	ack
Examiner Examiner		15. Decedent's Education (Spec	cify only highest grade co	ompleted) 16a.			ition (Give kind of w		16b.	Kind of Busines	ss/Industry
tygiene. other than "natu the Medical Exan	įΓ	Elementary/Secondary (0-12)	College (1-4 o					ea)		C Gover	
Hygiene. other than the Medical	Ĺ	Twelth	None	Da	ta/Ma	ail Cler				_	nt Program
h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho- matic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		17. Father's Name (First, Middle, Theodore Davis	,				18.Mother's Name Eva Ma		Maiden	Surname)	
tem 27 is ma traumatic ev	2	19a. Informant's Name/Relations Theodore C. Da		- 1			et and Number or R				
Department of Health a Important: If item 27 injury or other traum	1	20a. Method of Disposition 1 XX Burial 2 Cremation 4 Donation 5 Other Sp 21. Signature of Fun al Service Daniel w harri	ecify: License	State crema	ltory or oth	emorial ame and Addres	Cem 2000 s of Facility Rol	ert G.	Su:	itland,	or Town, State Maryland eral Home In
ician	_	23a. Part I. Enter the disease, or failure. List only one cause	complications that cause	d the death. Do n	ot enter th	ne mode of dying	Hope rd , such as cardiac or	respiratory ar	rest, sh	ock, or heart	Approximate Interval Between Onset and
dical niner		Immediate Cause (Final disease or condition resulting in death)	a. Pontine Hemo								Death
	1	Sequentially list conditions,	b				1.00				
ne		if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a con	sequence of):							
it xaminer		(Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of):							
≅ ш	1		d								
physician the burial -		UNPENDED	AMENDED								
attending physician and or use as the burial - tra	2	F FEMALE: 3b. Was decedent pregnant in th		ome of pregnancy	,				23	d. Date of deliv	•
for use as the sician/		past 12 months?	I Elve birti	at time of dooth	- H	al death 3 ner (Specify)	Ectopic pregnar	ncy		Month	Day Year
the atte	1	1 Yes 2 No 9 Unk	nown g Unknown		5 Otr	iei (Opecily)			4		
a [ag a		Part II. Other significant conditi	ons contributing to dea	th but not resultin	ng in the u	nderlying cause	given in Part I.	23e, Did 1	obacco	use contribute	to the cause of death?
signed The det		Cirrhosis of Liver						1 Ye	s 2	No 3 P	robably 4 Unknown
								24a. Was auto	psy	prior t	autopsy findings available o completion of cause of
as been s 2 should 1											
2 should								1 Yes	ormed?	death 1	
his certificate has been sig director, page 2 should be o Be Completed		25. Was case referred to medical examiner?	Hospital:			26.Plac	e of Death (Check of Other, Nursing	1 ✔ Yes			

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760,

> To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Medical Certification

1 V Natural Pending 2 Accident 3 Suicide

Margarita Korell MD

Investigation Could not be determined Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc

29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Signature and title of certific

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

Yes 2

29c. License number O.C.M.E.

2. Registrar's Signature

State

4

29b.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City

March 8, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 817 Catherine M. DiGiorgio /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Osedale nklin Savare Battlmor If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 06/10/1927 **Funeral** 1 □ M 2 👿 F Months Days Hours 81 Director <u> 215-28-6884</u> Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Modical Exeminating to conflict an once. Director 1 ☐ Yes 2 🔀 No Baltimore MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4315 E. Joppa Road 21236 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: ò Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Violet Schultz ပ Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas C. DiGiorgio, Son 4315 E. Joppa Rd., Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 03/20/2009 Hilltop Svc. Corp. Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Leonard J. Ruck, Inc. alexande 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final COPD **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed and Due to (or as a consequence of): burial-Box 68760. physician Physician/Medical the attending p as IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Day 4 ☐ Pregnant at time of death 5 Other (specify) P.0. signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed Yes 2 No certificate 1 ∐ Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: After this certifiing funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Many er of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

Live S. parl

are Dr. Batimore, MD 21237

Darren Jules Dachino

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

	For State Certificate of Death	and Mental Hygi	Reg. No.						
Physician/ al Examiner	. Decedent's Name (First, Middle,Last) Darren Jules D'AG	ah ina	Joseph Day Voor	Time of Death 0617 hrs					
,	a. Facility Name (if not institution, give street and number) 4b. City, Tow 8139 Park Haven Road Dundalk	vn, or Location of Death	4c. County of Death Baltimore County	V					
Funeral Director	215-84-1540 6. Sex 1 X M 2 F 47 Yrs. If Under 1 And 1 And 2 F 47 1 X M 2 F 47 1	Year If Under 24Hrs. 8.	Date of Birth (MM/DD/YYYY) 9. Birthpl Countr	ace (State or Foreign					
w any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Baltimore Dundalk								
after death with the Maryland al", or items 23a or 28a-f show iner must be notified at once. y Funeral Director	Maryland Baltimore Oe. Street and Number 8139 Park Haven Road		10g Citizen of What Country United State						
er death with , or items 23 r must be no Funeral		of Hispanic Origin? (Specificular, Mexican, Puerto Rica	white, etc.	Mhite					
within 72 hours aft giene. her than "natural" Medical Examine ompleted by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occurrence during most of working the complete of the	ocupation (Give kind of working life. DO NOT use retired)	done 16b. Kind of Business/Indu	ustry					
be filed within ntal Hygiene. It we other that ent, the Medicant, the Medicant, the Be Comp	12 Years Bulk Load 7. Father's Name (First, Middle, Last) Frederick S. D'Achino	18.Mother's Name (Fir	Lafarge C st, Middle, Maiden Surname) th A. Heil	oncrete					
th and Me 127 is man umatic ev	9a. Informant's Name/Relationship (Type, Print) Mrs. Dorothy D'Achino (Wife) 8139 Park	Haven Road	Route Number, City or Town, State, Zi	21222					
Pages I an tment of Hear reant: If iten or other tra	20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name crematory or other place) Hilltop Service	e Corp. 3/1:	2/2009 Towson, Ma	ryland					
Marini Depart injury	21. Signature of Funeral Service Licensee 22. Name and Ad Dud a - Rui 79.2 Wi 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of death.		ome of Dundalk, Indalk, Maryland 212						
Medical	failure. List only one cause on each line. mmediate Cause (Final disease or condition resulting in death) a Cardiomegaly with biventri Due to (or as a consequence of): dilatation	icular hypert		Between Onset and Death					
r xaminer	b. Due to (or as a consequence of):								
sician and sician and ourial - tra	X UNPENDED 23a,PII,27,perME, g889 3/17/09 TT								
# E 0 >	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown								
signed by the lbe detached dby Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying ca Morbid obesity	ause given in Part I.	23e. Did tobacco use contribute to the						
The taw requires are has been sig age 2 should be ompleted			24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes	osy findings available apletion of cause of					
ysician: The his certificate director, page	examiner?	Place of Death (Check only		-					
된 발표 누	27. Matural 5 Pending Pending 28a. Date of Injury (Month, Day, Year)		d. Describe how injury occurred	Cerie					
ppital or neral Dir filled in	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, of (Specify)		Location (Street and Number or Rural or Town, State)	Route Number, City					
Fo the Ho within 24 F Fo the Fu completely	29a. Certifier Check only 2 Certifying Physician: To the best of my knowledge, death occurred at the tire cone) 2 Medical Examiner: On the basis of examination and/or investigation, in my or and manner stated.	pinion, death occurred at the	e time, date and place, and due to the c						
Σ	anetz !	D.C.M.E.	29d. Date signed (Month) March 7, 2009	, Day,Year)					
	30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Ba	ltimore MD 21201							
State	Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Ba 31. Date filed (Month, Day, Year) MAR 1 6 2009 32. Degistrar's Signature	illimore, MD 21201							

		-	For State Registrar		State	of Mar	yland	-	artmen rtificate					Reg. No.	200	9	08057
	Physicia	an	1. Decedent's Name (Fi					_					2. Date of De Month	ath Day	Year		Time of Death
	/Medic	al	Mary		Κ		Du	nlow	45 035		Looption	of Dooth	3	11	2009 ounty of Dea		110 A M
	Examin	er	4a. Facility Name (If not				000	Ten			Location of				3 a L T		(e
_	Funeral		FRANKLIN S 5. Social Security Numb	er 6.5	Sex	7 Age /	In yrs. las	t birthday)	If Under	1 Year	If Under		8. Date of Bir				(State or Foreign
	Director		423-24-3536		1 □ м 2 1 1	F	82	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da October	3, 192	26 Ala	abama	a
	w		Usual Residence of Dec 10a. State 10t	edent c. County		1	0c. City,	Town or Lo	cation							10d. lr	nside City Limits
	Maryla f sho	ō		Baltim	ore			Dunda								1	1 □Yes 2 🙀 No
	r 28a-	Director	10e. Street and Number	-					10f. Zip	Code				10g. Citize	en of What C	Country?	~
	death with the Maryland		1525 Leslie	Road						21	222			Ţ	JSA		
⊼. 336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Medical Examitration into the rectifical at once.	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4		Armed 1 ☐ Ye	Decedent Eve d Forces? es 2 XNo , Give or Dates:	er in U.S.		Was Deced If Yes, spec 1 ☐ Yes				ecify Yes or No Rican, etc.)		I. Race - Am Black, Whi Specify: W	ite, etc.	
7.00-6	2 hou latura ic. E	ted	15.	Decedent's E	ducation	ead)		16a. Dece	dent's Usua kind of wor DO NOT us	l Occupa	ation	et of working	20	16b. Kind	d of Busines	s/Industry	у
mary 21215-0036	thin 7 ie. an "n	Completed	Elementary/Secondar	nly highest gr y (0-12)		ge (1-4or 5+))	i oi workii	iy				
2 12	ed wi lygien her th	ပ်	10 years	A # # :		-		НОІ	ısewii	:e	10 Moth	ar'a Namo	(First, Middle,	_	1 Home		
∧ Lo w Maryland	be fill he fill he ded ott	Be	17. Father's Name <i>(Firs</i> Charles Gla		7)								Bee Gla		urname)		
0 Z	hould id Me mark matic	으	19a. Informant's Name		(Type Print)			19b. Mailir	na Address	(Street a			I Route Numb		Town. State.	Zip Cod	
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×	the death certifica the attending pheched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 ☐ Yes 2 ☑ 10 9 ☐ Unknown	ths?	1 □ L 4 □ F	, outcome of Live birth 2 Pregnant at ti Unknown	Fetal d	eath 3[⊒ Ectopic p ⊒ Other <i>(sp</i>		/			23	3d. Date of d Month	lelivery Day	Year
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Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	Completed											24a. Was auto perfo	psy ormed?	prior to death?	o comple	findings available stion of cause of
ital	ian: rtifica stor, p	Be C	25. Was case referred	to medical							26. Place	e of Death	(Check only				
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12			30. Name and address	H N	La La La	190	OO F	AA N	Karalan	Sac	200	e Di	3/B	aLTO	md	20	1237
7	Sta Registi		31. Date filed (Month, L	Pay Year)	2009	cause of dea	Signatu	2 19	(Martin		- 6.70 Y		/				

			1 _ State		artment of H	lealth and Mental Hy	2000 00059
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	augher	ty	2. Date of De Month	12 09 645 am
	Examir Funeral Director	er	212-58-2770 1□ M 2☒ F	. Age (In yrs. last birthday) 57 Yrs.	Randails If Under 1 Year Months Days	If Under 24 Hrs. 8. Date of Bit	4c. County of Death Baltinore rth ay, Year) 1951 9. Birthplace (State or Foreign Country) M)
	e Maryland 8a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Baltimore	10c. City, Town or Lo Randallst			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	th with the 23a or 28	Funeral Director	10e. Street and Number 3739 Courtleigh Drive		10f. Zip Code 21133		10g. Citizen of What Country? USA
5-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examirer must be to diffied at		11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Deced Armed Form 1 ☐ Yes Given Year or Da	No 1	Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 🛣 No	spanic Origin? (Specify Yes or Non, Mexican, Puerto Rican, etc.) Specify:	o- 14. Race - American Indian, Black, White, etc. Specify: African-American
21215-0	should be filed within and Mental Hygiene. s marked other than " umatic event, Italia	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-	(Give	DO NOT use retired,	luring most of working)	16b. Kind of Business/Industry
land 21		To Be Co	12th 17. Father's Name (First, Middle, Last) unk		General Man	18. Mother's Name (First, Middle Shirley J. Rawling	
, Maryland		Ė	19a. Informant's Name/Relationship (Type. Print) Caroline A. Ovens / Sister	3739	Courtleigh	Drive Randallstow	n, MD 211.33
Baltimore,	permit. Pages 1 and 2 Department of Health i Important: If item 27 is any injury or other tra once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from S 4 □ Donation 5 □ Other (Specify) 21. Signature of Fune at Service Licensee	Metro Crema	TOLY 2. Name and Addres	3/14/2009	Baltimore, Maryland Al Home P.A. of Balto. Co.
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ear Immediate Cause (Final disease or condition resulting in death) Due to (condition condition can be condition.	uced the death. Do not ent			
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68760,	tificate be ig physici as the bu	ledical	d				
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months?	ant at time of death 5	Ectopic pregnancy Other (specify)	1	23d. Date of delivery Month Day Year
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of Vital Records,	ician: The law r certificate has be ector, page 2 sh	Completed				1 □ Yes	psy prior to completion of cause of death? 2 ☑ No 1 ☐ Yes 2 ☐ No
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ion of	ng Phys fter this ineral di	Certification: To	27. Manner of Death 1 Natural 5 Pending investigation 28a. Date o (Month)	patient 2 ☐ ER/Outpatier f Injury , <i>Day</i> , Ye <i>ar</i>) 28b. Time o Injury	28c. Injury Work	4 Li Nursing Home 5 Lyrkes	idence 6 Other (Specify) how injury occurred
Division	i di di		4 ☐ Homicide determined buildin	of Injury - At home, farm, str g, etc. <i>(Specify)</i>		City or To	(Street and Number or Rural Route Number, wn, State)
1	the Hospital hin 24 hours a the Funeral mpletely filled	ledical	one) and mann	sis of examination and/or in	vestigation, in my o	pinion, death occurred at the time	, date and place, and due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	o mi	29c. Dicense	46267	29d. Date signed (Month, Day, Year) 3/13/09
			30. Name and address of person who completed cause 2 +11 W, Selved	of death (Item 23a) (Type,	Balt	more me	21215

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene Zerlificate of Death Reg. No. 2 1 - For State Registrar 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Edward W. Erbe, Jr. AM 0145 MARCH 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A AGNES BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 1₺ м 2□ F 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 82 220-20-2620 Director 18, 1927 Maryland Jan. Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at Maryland Anne Arundel Co. Glen Burnie 1 □Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 115 Furnlea Dr. 21060 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XXYes 25140 If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Itimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: 2 Specify: White 3 N Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 72 in and Mental Hygiene... 7 is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) Project Engineer Candy Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward W. Hazel Sank 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 i Ms. Pam Conwell / Daughter 8025 Greentree Ct. Elkridge, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 Date 20c. Location - City or Town, State Department of I Important: If its any injury or o once. f⊞Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vet. Cemetery 3/13/2009 Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation N101220 Services, PA; 1 2nd Ave SW, Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 5min disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami and Due to (or as a consequence of): Box 68760. attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 100 1 ☐ Yes 1 ☐ Yes 2 ☐ No Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | 1 | 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 **ertifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year March 7, 2009 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

31. Date filed (Month, Day, Year)

Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 10 Day **Physician** 2009 6:45 A M Paul Henry Fox /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick 919 N. East Street #E Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 XM 2 □ F 213-46-2064 1944 Maryland 64 Oct. 29, Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Wedical Examiner must be notified at 1 ☐ Yes 2 XNo Director Frederick Union Bridge Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10370 Fountain School Rd. 21791 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify. Specify: White þ 3 ☐ Widowed 4X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) laborer stair construction Department of Health and Mental Hygi Important: If item 27 Is marked other any Injury or other traumatic event, I once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Cashour Henry R. Fox ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Ann Fox Walter/stepmother 10370 Fountain School Rd. Union Bridge, MD 21791 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State All County Cremation: 3/11/2009 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Lice atharine 6 E. Broadway Union Bridge, MD 21791 23a. Part 1. Enter the disease, or complications that the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **ASCVD** 10 yrs. disease or condition resulting in death) /Medical Due to (or as a consequence of): 15 yrs. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant In the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ

Physician Examiner

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a

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26. Place of Death (Check only one,

Hypertension

. Was an autopsy performed? Pyes 2 ⊠No 24b. Were autopsy findings prior to completion of cleath?	available

25. Was case examiner?		d to medical
1 ☐ Yes	2 N	0
27. Manner of	Death	
1 Natura	al	5 Pending

5 ☐ Pending investigation 2 Accident 3 ☐ Suicide 6 Could not be

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

Other: 4 \sum Nur 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

sing H	ome	5 🗌 Residence	6 ⊠Other (Specify)	at	work
	28d.	Describe how inju	ury occurred		

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

28f. Location (Street and Number or Rural Route Number, City or Town, State)

and manner stated 29b. Signature and title of certifier

29c. License number 20020330 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Lehigh 31. Date filed (Month)

(Check only onel

> 104 N. Main St. 32. Registrar's Signature

Union Bridge, MD 21791

State Registrar

Completed

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after death. Director: Al

within 24 hours a

To the Funeral D To the Hospital

or Attending

Certification:

Medical

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 8:15 PM Physician March 5000 Thomas Fisher /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1 X M 2 □ F 281-34-9962 69 Dec 30, 1939 Director Usual Residence of Decedent 10d. Inside City Limits should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Medical Experience coust by no Miled at MD 1√2 Yes 2 □ No Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2327 N. Charles Street 21218 USA Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.Sunk Armed Forces? Black, White, etc. 1 ∐Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2X No Baltimore, Maryland 21215-0036 Specify. Specify: white þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation unk 15. Decedent's Education (Specify only highest grade completed) unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk Be ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health an
Important: If Item 27 is I
any Injury or other traui E. University Pkwy Baltimore, MD 21218

obsition (Name of Date | 20c. Location - City or Town, State Union Memorial Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🛛 Other (Specify) in state 21. Signature of Euroral Service licensee Wine Brector 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cau (Final disease or condition resulting in death) RUMUCOCC **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as \ consequence of) ner law requires that the death certificate be executed Exami Due to (or as a consequence of): burial-1 physician s the burial Box 68760, Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown s been signed by to should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performed?/ 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t 5 Pending 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Memorial Hospital, MO insado HCKKU 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** GOODE JR. 6:50 AM MARCH 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BON SECOURS HOSPIJAL BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Manth, Day. 7. Age (In yrs. last birthday) Yrs. Social Security Number Birthplace (State or Foreign Country) **Funeral** i XM 2□ F Director Cama Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Madical Examinar is ust be notified at Yes 2 □ No Director TimoRe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 No Specify: <u>\$</u> Snecify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygi item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Be be ပ္ oldest 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Goode -days 110 If item 27 or other t Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State Pages 1 1 Burial 2 ☐ Cremation 3 Removal from State permit. Page: Department o Important: If any injury or MARCH 19,2009 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licens Approximate Interval Between Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner BE Physician: The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of): attending physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) detached 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has autopsy performed 2.1 No 1 □ Yes 2 2 No 1 TYes funeral director. 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 Natural 5 Pending 1 ☐Yes 2 ☐No investigation death. 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

P.0. Division of Vital Records. To the Hospital

> State Registrar

completely

Medical

(Check only

31. Date filed (Month, Day

29b. Signature and title of certifier

MAR 16

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Si

ature

1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

00030355

29d, Date signed (Month, Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Gobble Billie Joe nava 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Cale Ba Square 08 Sec If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Hours Days Months 1 XM 2 ☐ F 59 229-72-2149 Yrs April 30,1949 Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, In. M. dical Evaning the notified at once. 1 ☐ Yes 2 No Middle River Director Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 202 Larkspur Lane 21220 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. Arring 1 GNO 1 GYes 2 No IfYes, Give Year or Dates: Vietnam 1 Never Married 2 X Married 1 ☐ Yes 3€No Specify Specify: Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Air Conditioning & Elementary/Secondary (0-12) College (1-4or 5+) Refrigeration Refrig./A.C. Mechanic 7 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Flora Jones Edward Lee Gobble 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. LuAnn Gobble (Wife) 202 Larkspur Lane Middle River, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest V.A. Cem. 3/12/2009 5 ☐ Other (Specify) Owings Mills, MD 4 ☐ Donation 22. Name and Address of Facility
Huda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 Signature of Fyneral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fature. Lier only one cause on each line. Approximate Interval Between Onset and Death Physician disease or condition resulting in death) /Medical Due to (or as a co quence of): **Examiner** erinscl Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: sate has been signed by the attendin page 2 should be detached for use yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>۾</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 \(\bigcap \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this funeral Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number o completed cause of death (Item 23a) (Type, Print) 30. Name and add Square Yea State MAR 16 2009

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per INF State of Mary land J Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2009 Month **Physician** Guldan A^{M} Ernestine Agnes March 13, 5:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford Belair If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Days September 13, 1913 95 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important; If item 27 Is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, Ire Medical Examinating the natified at 1 ☐ Yes 2 XNo Director Maryland Conowingo Cecil 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21918 USA 22 Cinnamon Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 □Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married USS U_j DOIS Oq/i3/i3 jBaltimore, Maryland 21215-0036 1 ☐Yes 2 🛣 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 3 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Justina Pauk Martin Mecler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 22 Cinnamon Drive, Conowingo, Maryland Patricia A. Repko Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Marchate 18, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus Cem. 2009 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Qignature of Fungral Service Ligen Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. ME Approximate Interval Between Onset and Death 23a. Par LE frer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Undarry g Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-tran Due to (or as a consequence of): ed by the attending physician detached for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months 1 ☐ Yes 2 ☑ No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 山|dan Ernを分れる Division of Vital Records, þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ Mo Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Man r of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 V atural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1... Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical ExamIner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Cew MD 200 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 1/2001

			For _ State	State of	Maryland	-			ealth and M		4	009	08065
			Registrar	4 4)		Cer	tificate	OID	eam	2. Date of De	Reg. No.		2. Time of Death
	Physicia	an	Decedent's Name (First, Middle,	C						Month 3	Day	Year	3. Time of Death
	/Medic		Laverne		man	<u> </u>			and the set Death	ح		200	
	Examin	er	4a. Facility Name (If not institution,			1	4b. City, 1		ocation of Death		4c. C	ounty of Deat	n
eł .			Oniversity of 5. Social Security Number	- Mary	Age (In yrs. las	et hirthday)	If Under		If Under 24 Hrs.	8. Date of Bir	rth	9. Birt	hplace (State or Foreign
	Funeral Director		161–30–6003	1 ☐ M 2 🔀 F	70	Yrs.	Months	Days	Hours Min.	(Month, Da	ay, Year)	Co	untry) nsylvania
			Usual Residence of Decedent		, 0					barr.	J, 17	33 J. CIII	ibyivania
	yland Now		10a. State 10b. County			Town or Loc							10d. Inside City Limits
	Mar.	tor	PA Lebano	on	Jo	nesto	νn						1 ☐ Yes 2X No
	h the	ire	10e. Street and Number				10f. Zip	Code			10g. Citiz	en of What Co	untry?
	th wit	a L	208 N. Fisher S	treet			1	7038			U.S.	Α.	
	filed within 72 hours after death with the Maryland Hygene. Hygene. the Wester standard than "natural", or items 23a or 28a-f show ent, the Modical Evanine must be notified at	Funeral Director	11. Marital Status	12. Was Deced	lent Ever in U.S. ces?	13. V	Vas Decede Yes, speci	ent of His	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.))- 1	 Race - Ame Black, White 	
9	or it	by Fu	1 Never Married 2 Marrie	If Yes, Give	e	1	□Yes 2	⊠ No	Specify:			Specify: Whi	te
2-003p	ural"	D D	3 ☐ Widowed 4 ☑ Divorced	Year or Da	tes:	16a. Deced	lant'a Llaua	LOcaupa	tion			d of Business/	
ç	"nat	Completed	15. Decedent's (Specify only highest	grade completed)		(Give I	kind of work OO NOT use	k done du	ıring most of work	ing		u oi busiilessi	muustry
7	within ene. than	广	Elementary/Secondary (0-12)	College (1-	4or 5+)	Cook		,			Sch	nool	
7 D	filed Hygi ther	ပို	17. Father's Name (First, Middle, L	ast)					18. Mother's Name	e (First, Middle	, Maiden S	urname)	
and	d be ental ked c	To Be	Mitchell Seiber	t					Pauline	McQuate	e Stoe	ever	
<u>-</u>	should be f and Mental I s marked of umatic eve	Ĕ	19a. Informant's Name/Relationsh		1	19b. Mailin	g Address	(Street a	nd Number or Rur	al Route Numb	er, City or	Town, State, 2	Zip Code)
>	nd 2 sulth a s		Beth Ann Hilton			808 M	aple	Lane	, Lebano	n,PA 17	7046		
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examiner must be notified at once.		20a. Method of Disposition		20b. Pla	ice of Dispos	sition (Nam	e of)] , [Date	20c. Loc	ation - City or	Town, State
Baltimor	Page ent o nt: If ry or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		tate West	t Arun	delCr	emat	ory Marc	n 16	Odent	on, MD	
	mit. F oortan inju		21 Signature of Funeral Service L	-		22	. Name and	d Address					Home, P.A.
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			23a. Part 1. Enter the disease, or	complications that ca	used the death.	Do not ente	er the mode	e of dying	, such as cardiac	or respiratory a	arrest,		Approximate Interval Between
	Physician	V . 1	shock, or heart failure. List of Immediate Cause (Final	ornly one cause on ea	1 1			C	1.10				Onset and Death
Y	/Medical		disease or condition resulting in death)	a. Due to (or as a conseque	occordence of):	<i>M</i> 1	101	1010				
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	ocuter nd ransi	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	с									
Ď,	e exe	Ä	resulting in death) Last	Due to (d	or as a conseque	ence of):							
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Õ	ertific ling p e as 1	Me	IF FEMALE:	T		15.77							
X P P	death certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	come of pregnan irth 2 Fetal o	death 3	Ectopic pr				2	3d. Date of de Month	livery Day Year
<u>.</u>	the a	sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregn 9 ☐ Unkno	ant at time of de own	ath 5∟	Other (sp	ecity)					
7.	w requires that the death been signed by the atter should be detached for u	F	Part II. Other significant conditio	ns contributing to de	ath but not result	ting in the ur	nderlying ca	use dive	n in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?
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Ö	requires t been signe should be	ied								0.1		041 144	
Kecords,	e 2 sl	Completed								24a. Was		24b. Were at prior to death?	utopsy findings available completion of cause of
<u>=</u>	cate pag	වි								1 □ Yes	2 No		2 □ No
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5	Jing I. After funer	io.	27. Manner of Death 1 Natural 5 Pending	(Mont	h, Day, Year)	Injury	M	Work'	? ^{°°°} ′es 2 □No	zou. Describe	now injury	00001100	
<u>s</u>	ttenc death stor: , the	icat	2 Accident investig 3 Suicide 6 Could n		of Injury - At hon	ne farm str	- 1		63 2 1110	28f Location	(Street and	Number or B	ural Route Number,
Division of	or A after Direction by	ertification:	4 ☐ Homicide determi	ned buildir	of Injury - At honing, etc. (Specify))	00t, ladtory,	, 011100			wn, State)	74477201 01 71	
	spital ours neral filled	O	29a. Certifier	g Physician: To the	best of my know	rledge, deatl	h occurred	at the tim	ne, date and place	, and due to the	e cause(s)	and manner a	s stated.
	To the Hospital or Attending Physician: The law within Eu hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical	(Check only 2 Medical one)	Examiner: On the ba and mann		on and/or in	vestigation	, in my op	oinion, death occu	red at the time	, date and	place, and du	e to the cause(s)
	ro th within Fo th	Me	29b. Signature and title of certifier	1 4			29c	. License	number		29d. Date	signed (Mon	th, Day, Year)
	10) () ()	17	MD			P	22-11	04	3	114/0	29
			30. Name and address of person	who completed caus	e of death (Item	23a) (Type,	Print)	,		- /		1	
	5		10	ates	22 S.	616	con	: 5+	-, Bar	timos	~	MD	21201
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	Registi	rar	MAR 16	2009 A	neva,	D. 1	acres						

State of Maryland / Department of Health and Mental Hygienes o o

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1	/Medica		4a Facility Name	If not institution, give	e street and number	9r)		4b. City, Town,	or Location of Dea	th 4c. County	of Death	
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			5. Social Security	- V 11 UA	enter to	Age (In yrs. last b	irthday) If Under 1 Y				Birthplace (State or Foreign Country)	
	Funeral Director		218-20-7	037	□M 2🂢 F	81	Yrs. Months D	ays Hours M	Min. (Month, D Aug 6,	1927	Maryland	
	land	ŀ	10a. State	10b. County		10c. City, Tov	vn or Location				10d. Inside City Limits	
	Mary Mary	į	MD	Washingt	on	Hag	erstown				1 ☐ Yes 2 ☐ No	
	3e or 28a	Funeral Director	10e. Street and No.	_{umber} lumbia Roa	ıd		10f. Zip Co	de 21742		10g. Citizen of V	•	
Maryland 21215-0020	as	合		rried 2 Married	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s;? XINo	13. Was Decedent If Yes, specify 1 \(\text{Yes} \) Yes 2\(\text{X} \)		? (Specify Yes or N ruerto Rican, etc.)	Blac	ee - American Indian, ck, White, etc. v:White	
5-0	72 ho	2	(So	15. Decedent's Ed	ducetion	168	a. Decedent's Usual O (Give kind of work of life. DO NOT use r	ccupation one during most of	working	16b. Kind of B	usiness/Industry	
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ınd	d off	å R		(First, Middle, Last,							,,,,	
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	1 and 3 Health em 27 l	-	20a. Method of Di		agneer	20b. Place	of Disposition (Name	of	Date		- City or Town, State	
Baltimore,	Paga nanto unt: If		1 🗆 Burial 🛭	Cremation 3 5 Other (Specif		cemet	ery, crematory or othe	r place)	1			
Balt	pemit. Pa Departmar Important: eny injury once.		21. Signature of	Ronald Service Lider	Wade, Di	rector	State An Baltimor		ard 655 W 1201	. Baltim	ore Street	
		\dashv	23a. Part . Enter	the disease, or com	plications that cause	sed the death. Do	not enter the mode o	f dying, such as car	rdiac or respiratory	arrest,	Approximate Interval Between	
7	Physician		snock or ne	eart failure. List only	One cause on eac	ii iirie.					Onset and Death	
-	/Medical		Immediate Cause disease or condit		Pu	Imor	my	MASS				
н	Examiner		resulting in death)	a		a consequence of):					
	7 -	edical Examiner										
	ifficate be executed g physician and as the burial-transit		Sequentially list of	conditions,	b	Due to (or as a	a consequence oi).					
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	v raquiras that tha daath cert been signed by the attendin should be detached for usa	Completed by Physician/M	Part II. Other algr	rificant conditions	contributing to deat	h but not resulting	in the underlying caus	se given in Part I.	23b. Die	d tobacco use co	ontribute to the cause of death?	
P.0	d by	£							1[Yea 2□ No	3 □ Probably 4 Unknown	
5,	ras th	<u> </u>							24a We	es an autopsy	24b. Were autopsy findings	
Records,	raqui een : hould								per	formed?	available prior to completion of cause	
ec	The law ate has b	힐									of deeth?	
	sician: The law certificate has t lirector, paga 2 s	ភ្ជ							1	Yes 2 No	1 ☐ Yes 2 No	
/ita	ysician: is certific director,	Be	25. Was case ref examiner?	erred to medical	Hospital			Other 8	f Death (Check only		,	
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ב	rng P	5	27. Manner of De 1 Natural	5 Pending	28e. Dete of (Month,	Dey Year)	Injury M	Injury at Work? 1 ☐ Yes 2 ☐ No		e now injuly occur	100	
Sio	Attending r death. Sctor: After by the fune	cat	2 ☐ Accident 3 ☐ Suicide	investigation		Maium. At home				(Street and Num	ber or Rurel Route Number,	
Division of Vital	or Att		4 Homicide	determined	200. Place 0	, etc. (Specify)	farm, street, factory, o	illoe	City or T	own, State)		
	urs a urs a liled illed	ပ္	00- O	4 🗆 0 - 114 / PI		and of my knowledge	ge, death occurred at	the time, date and r	place, and due to th	e ceuse(s) and m	anner as stated	
	To the Hospital or Attending Phywithin 24 hours aftar death. To the Funeral Director: After thi completaly filled in by the funeral	edical Certification:	29a. Certifier (Check only one)	2 Medicai Exa	miner: On the basi and manne	is of examination a	and/or investigation, in	my opinion, death	occurred at the time	e, date and place,	and due to the cause(s)	
	within To the compl	ğ.	29b. Signature au	ad title of certifier				icense number			ed (Month, Day, Year)	
	->-0		1	-111			D	4795	5	3/10	. 2009	
			30. Name and ad	dress of person who	completed cause	of death (Item 23a) (Type, Print),	N		•		
			SIBTE	A KAZI	41 HD	214-	TOIL HO	WHE H	IVE true	EDETHC	. 2009 16 HD 2170	
	Stat	é	31. Date filed (M		37 Rec	itstrar's Signature	bare					
	Registra			MAR 1620	09 Centre	M. B.	parel					

		•	For Amend Items State Registrar	.oa-r per me,	Cer	tificate of l	Death	R	eg. No2005	08067	
	Physicia	an	1. Decedent's Name (First, Middle, Last) John Clinton	Hyde				2. Date of Deat Month March	Day Year		
	/Medic Examin		4a. Facility Name (If not institution, give stre			4b. City, Town, or	Location of Death	Haren	6 200 4c. County of De		
	⊏xamın	er	Washington Adventis				na Park		Montgo		
	Funeral Director		5. Social Security Number 5.21-64-2472 6. Sex 1 ☑ M	2□ F 7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 11/11/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/	9. B 944 C	irthplace (State or Foreign Country) olorado	
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	ation	<u> </u>			10d. Inside City Limits	
	Mary!	tor	MD Montgomer	cy		Takor	na Park			1X∑Yes 2 No	
3	3a or 28a	al Director	10e. Street and Number 1114 Merwood Rd.			10f. Zip Code	20912	1	10g. Citizen of What Country? United States		
2-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fulury or other traumatic event, I'm Medical Expirition must be notified at once.	by Funeral	1 Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 Mg No if Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, Wh	nerican Indian, ite, etc. White	
215-0	hin 72 ho e. an "natur Medical	Completed	15. Decedent's Educati (Specify only highest grade co	on mpleted) College (1-4or 5+)	(Give I life. E		during most of work d)	ing	16b. Kind of Busines	-	
2121	ed with ygiene ser the t, the	Con		4	Aut	hor / Jo		/First Middle	Print Me Maiden Surname)	dia	
Maryland	should be fill and Mental H is marked oth	To Be	17. Father's Name (First, Middle, Last) Kenneth Morri	son Hyde			Ethel	Irene	e Kouts		
	and 2 sho ealth and 1 n 27 is ma ner trauma	ľ	19a. Informant's Name/Relationship (Type. Louise Swartzwalde				and Number or Rui Rd., Tak		r, City or Town, State		
w	Pages 1 annent of Heannt of Heannt of Heannt of Heannt II item		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	20b. Pla		sition (Name of natory or other place e Cremat		Date 12,	20c. Location - City of Beltsvill		
Baltir	Department Department Importar any injur		21. Signature of Funeral Service Licensee	1100382	22 R	. Name and Addre	ss of Facility ral & Cre Ave., Sil	mation S	Services	20910	
	25.00		23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of	ions that caused the death.						Approximate Interval Between Onset and Death	
in F	Physician		Immediate Cause (Final disease or condition	SUBJU	AAL	-Jerm Foll	mA			Onset and Death	
2	/Medical Examiner		resulting in death)	Due to (or a conseque	ence of):	עלאט					
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	ecutec and I-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):	1, 14					
68760,	rtificate be executed ng physician and as the burial-transit	Medical E	L d	1/2 3/12/9							
		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23d. Date of Month	delivery Day Year					
ds, P.	w requires that the de been signed by the should be detached		Part II. Other significant conditions contri	outing to death but not result	ting in the u	nderlying cause giv	ven in Part I.	23e. Did to	_J	e to the cause of death? Probably 4 Unknown	
Division of Vital Records,	E 25 C	Completed by						24a. Was a autop perfor	sy prior męd : death	autopsy findings available to completion of cause of ? es 2 \(\square\$ No	
Vita	iclan: certific ector,	Be	25. Was case referred to medical examiner?	pital:		Ott	26. Place of Dea				
o	g Physer this eral dil	일	27. Manner of Death	28a. Date of Injury	28b. Time o	f 28c. Inju	4 🗆 Nulsing II	28d. Describe h	lence 6 Other (S low injury occurred	pecity)	
sion	tending eath. or: Aft	catio	1 Natural 5 ☐ Pending 2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be	3/4/01	Unknow	M 1	Yes 2/10 No	Subjec		Duri Davis Mumber	
Divi	To the Hospital or Attending Physician: The I Within 24 hours after death. Ty the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify Home	me, farm, str	eet, factory, office		City or Tou	Park, MD	Bural Route Number, Merwood Road	
	Hospi 24 hour Funer etely fill	Medical	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	ian: To the best of my know r: On the basis of examinat and manner stated.	vledge, deat ion and/or ir	h occurred at the to restigation, in my	ime, date and place opinion, death occu	e, and due to the rred at the time,	cause(s) and manne date and place, and o	r as stated. due to the cause(s)	
	To the To the comple	Mec	29b. Signature an orbitle of codiner	Lbe		29c. Licen	se number		29d. Date signed (M	onth, Day, Year)	
	(0)		T) 44	PHT	h-		>0771		WERTH	4 YOUN	
			30. Name and address of person who com	mb 2101	Med Or	K. Bark 1	Rive N.	Se 305	Silver don	g M) 20902	
	St Regist	ate	31. Date filed (Month, Day, Year)	Registrar's Signat	ure La	res			V	/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 0845 2009 March 12, John Board Hall, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2902 Ohio Avenue Baltimore Highlands Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 XM 2 □ F 77 30°. 1931 218-26-3129 Maryland Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show ?7 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be autified at 1 ☐Yes 2X No MD Baltimore Highlands Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21227 2902 Ohio Avenue United States Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Folces.
Yayes 2 If Yes, Give Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Exemina any injury or other traumatic event, the Medical Exeminations. 1 Never Married 2 X Married 1 ☐Yes 2 📉 No Specify Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Utilities Gas Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Berard D. Hall Beatrice E. Fossler 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nadine Hall - Wife 2902 Ohio Avenue, Baltimore Highlands, MD 21227 20b. Place of Disposition (Name of MD cameter), crematory or other place)

MD veterans cemetery 3-16-2009 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, MD 4 Donation 5 Other (Specify) Crownsville 22. Name and Address of Facilit Ambrose Funeral Home, Inc. of Funeral Service Ligense 21. Signatur 1328 SUlphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ver O year **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed after death. nding physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>^</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate ours after death. eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Naccident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide

P.O. Box 68760,

Baltimore, Maryland 21215-0036

Division of Vital Records. To the Hospital within 24 hours a To the Funeral C the Hospital

Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number person who completed cause of death (Item 23a) (Type, Print) den Choice La Catonsville MD21276 31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 12:20 P M 14 2009 March Charles Earle Hoover 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Carroll Westminster Carroll HospiceDove House If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, You Aug. 29, 9. Birthplace (State or Foreign Year) 1933 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Days Hours Months Märyland 1**X** M 2□ F Aug. 75 218-32-2098 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Keymar Maryland Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21757 685 Francis Scott Key Highway Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 1 Never Married 2 Married White 1 ☐Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) stair construction master carpenter 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Regina Elizabeth Grossnickle Charles Oscar Hoover 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 685 Francis Scott Key Hgwy. Keymar, MD 21757 Esther B. Hoover/ wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Grace U.C.C. Cemetery 3/18/2009 Taneytown, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service License Jarine 6 E. Broadway Union Bridge, MD 21791 att 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) ven in Part I.

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Margine II.

Baltimore, Maryland 21215-0036

/Medical

Funeral Director

Completed by

Be

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ng physician and as the burial-tran page 2 should To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p.

P.O. Box 68760,

Division of Vital Records,

Examine Physician/Medical <u>۾</u> Completed Be Certification: To

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnand 5 ☐ Other (specify)
Part II. Other significant condition	s contributing to death but not resulting in	the underlying cause gi

nancy y)			ate of deli	ivery Day	Year	
e given in Part I.	23e. Did tobacc	o use con			se of death?	
	24a. Was an autopsy performed	24b.	Were au	topsy fir completi	ndings available on of cause of	
26. Place of Death (Check only one)					
Other: 4 \(\text{Nursing Home}	5 Residence	6 ⊠Ot	her (Spe	cify) h	ospice	
Injury at Work? 1 □ Yes 2 □ No	d. Describe how in	jury occu	rred			
ze 28f. Location (Street and Number or Rural Route Number, City or Town, State)					te Number,	
te time, date and place, and due to the cause(s) and manner as stated. ny opinion, death occurred at the time, date and place, and due to the cause(s)						

3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	, street, factory, office
29a. Certifier (Check only one)	1 Certifying Physi Medical Examine	clan: To the best of my knowledge, der: On the basis of examination and/c and manner stated.	leath occurred at the time, date and or investigation, in my opinion, death
29b. Signature and	title of certifier		29c. License humber

28a. Date of Injury (Month, Day, Year)

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

29d. Date/signed (Month, Day, Year)

State Registrar

To the Hospital within 24 hours as To the Funeral D

Name and address of person who completed cause of death (Nem 23a) (Type, Print)

5 Pending

6 □ Could not be

25. Was case referred to medical examiner?

1 ☐ Yes

27. Manner of Death

1 Natural

2 Accident

Medical

enter Street Wastminister

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day Physician 12:45 a^M March 13, 2009 Robert Thomas Halstead. Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Brinton Woods Nursing and Rehab Sykesville Carrol1 8. Date of Birth (Month, Day, Year) 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 ☑ M 2 ☐ F Michigan Director Sept 8, 1936 374-32-6170 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h Counts 28a-f show other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 ☐ Yes 2√x No MD Carroll Westminster 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 502 Lakes Court items 23a 21158 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married ō 1 ☐ Yes 2 ☑ No Specify: Specify: ρ Yes, Give Year or Dates: 3 ☐ Widowed 4 ☒ Divorced White 'natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Insurance Adjustor Workman Comp 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) n and Mental F Be Ceci1 Halstead Eleanor L. Gann ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i 502 Lakes Court Westminster, MD 21158 Elizabeth W. Pedlar Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition **₽** 6 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 3/18/09 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet Owings Mills, MD 22. Name and Address of Facility 11824 Reisterstown Road Signature of Funeral/Service Licensee ine ELINE FUNERAL HOME Reisterstown, MD 21136 Approximate Interval Between Onset and Death 23a. art 1. Enter the disease, or complications that cause I the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant contitions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>δ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 1 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Æ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27, Mann of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and marmer stated. 29d. Date signed (Month, Day, Year) 29b, Signature and title of certifier al sel 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RNB 4176 31. Date filed (Month, Day, State 6 2009

DHMH 17 Rev 1/2001

Registrar

Saltimore, Maryland 21215-0036

Box 68760.

P.O.

Records.

Division of Vital

			For State of Ma State Registrar	aryland / Depa <i>Ce</i>	artment of H <i>rtificate of l</i>			eg. No. 2009	08071
40	Physici		1. Decedent's Name (First, Middle, Last) Theodore Hard				2. Date of Deat Month March	15 2009	3. Time of Death 7:20a M
1	/Medio		4a. Facility Name (If not institution, give street and number) Fairhaven		4b. City, Town, or Sykesvi	Location of Death		4c. County of Deat	h
	Funeral Director		5. Social Security Number 6. Sex 7. Age 1 1 1 1 2 □ F 83	e (In yrs. last birthday) Yrs.		If Under 24 Hrs.	8. Date of Birth (Month, Pay, Sept 11	9. Birt	hplace (State or Foreign untry) CT
	e Maryland ka-f show tified at	ctor	Usual Residence of Decedent 10a. State 10b. County MD Carrol1	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	h with the	Funeral Director	10e. Street and Number 7200 Third Avenue		10f. Zip Code 21784		1	0g. Citizen of What Co USA	untry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ ₩idowed 4 □ Divorced 12. Was Decedent E Armed Forces? 1 □ Yes 2 □ N If Yes, Give Year or Dates:	10 17777	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 21 No	ispanic Origin? (Spe in, Mexican, Puerto i Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: whi	e, etc.
Baltimore, Maryland 21215-0036		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5 +5)	(Give	dent's Usual Occup e kind of work done o DO NOT use retired SSIONATY	ation during most of workii l)	ng	16b. Kind of Business/ MISSIONS	Industry
land 2	ld be filed ental Hyg ked other ic event, 1	To Be C	17. Father's Name (<i>First, Middle, Last</i>) Ernest Hard			18. Mother's Name Anne Con		Maiden Surname)	
Mary	Pages 1 and 2 shoulinent of Health and Ment of Health and Ment. If item 27 Is mark ury or other traumatiin		19a. Informant's Name/Relationship (Type. Print) Gregory T. Hard (son)		; City or Town, State, 2 sville, Md				
imore,		100	20a. Method of Disposition 1 X Burial 2 □ Cremation 3 X Temoval from State 4 □ Donation 5 □ Other (Specify)		20c. Location - City or Town, State Mt. Morris, PA				
Balt	permit. Departr Importa any Inj		21. Signature of Funeral Service Licensee Page Saight		2. Name and Addres			eral Home 8 0 21784	Chapel
	Physician /Medical Examiner	resulting in death) a. Due to (or as a consequence of):						est,	Approximate Interval Between Onset and Death
0,	ficate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events c.	a consequence of):					
P.O. Box 68760,	death certi e attending d for use a	Physician/Medical	d		23d. Date of del Month	ivery Day Year			
	law requires that the as been signed by the 2 should be detache	þ	Part II. Other significant conditions contributing to death bu	ut not resulting in the u	ınderlying cause give	en in Part I.	23e. Did tob	oacco use contribute to	the cause of death?
Division or Vital Records,	The ate h page	Completed						y prior to death? 2 No 1 □ Yes	topsy findings available completion of cause of 2 ☐ No
r Vit	ysiclar is certif	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Outpatie	nt 3 DOA Othe	26. Place of Death		ence 6 □Other (Spe	cify)
io uoi	or Attending Physician: ifter death. Director: After this certifica in by the funeral director, i		27. Manner of Death 1 XNatural 5 Pending (Month, Day 2 Accident investigation	ry 28b. Time o	Worl			w injury occurred	,
Divis	al or Atte s after des al Directo ed in by th	Certification:	3 Suicide 6 Could not be determined 28e. Place of inju	ury - At home, farm, st c. (Specify)	reet, factory, office	2	28f. Location (St. City or Town	reet and Number or Ru , State)	ral Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of Medical Examiner: On the basis of and manner sta	f examination and/or in ated.	nvestigation, in my o	pinion, death occurr	ed at the time, d	ate and place, and due	to the cause(s)
R	To the within 2 To the complete	Ž	29b. Signature and title of certifier		D31	4849	2	9d. Date signed (Monti Mach i) 2178	o 2009
			30. Name and address of person who completed cause of de William Tan Wa 1645	eath (Item 23a) (Type, 5 Liberty	Print) Road 8	E Idersbu	3 MD	2178	t
	Sta Registi		31. Date filed (Month, Day, Year) MAR 1 6 2009 Lenux	ar's Signature	de				

DHMH 17 Rev 1/2001

VOID

CERTIFICATE

2009 - 08072

SEE

CERTIFICATE #

2008 - 43755

		-	For State Registrar		Sta	te of M	arylan		artmen rtificat			and M	lental Hy	giene Reg. No.	Z 11	09	08073
	Physici	an	1. Decedent's Name	e (First, Middle	e, Last)								2. Date of De Month	Day		Year	3. Time of Death
	/Medic			Bell Le									March	13	2	009	11:00 A M
	Examin	er	4a. Facility Name (/								Location o					of Death	
-	F		W1LSOn 5. Social Security N	Health	6. Sex			last birthday)			sbur If Under		8. Date of Bi	rth	Mont	gome 9. Birtho	ry lace (State or Foreign
	Funeral Director		228-24-0		1 □ M 2		90	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D January	3, Year)	19	Coun	ington, D.C.
			Usual Residence of			ı											
	arylar show	늘	10a. State	10b. County				y, Town or Lo								111	0d. Inside City Limits 1X Yes 2 □ No
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	ns 23	Funeral	11. Marital Status	ssell r		s Decedent	Ever in U.	S. 13.1				igin? (Spe	ecify Yes or No Rican, etc.)			e - Americ	
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933	ral",	d by	3 🕅 Widowed	4 Divorced	Yea	es, Give ar or Dates:			1∐Yes 2	2 X 1140	Specify:				Specify	Wh	ite
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121	within ene. than	дшо	Elementary/Seco	ondary (0-12)	Coll	lege (1-4or 5	i+)		mit F					1	_		Suburban mmision
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<u>a</u> n	ld be lental ked c	To Be	Joseph	Kirkwo	od Lew	is					Ba	rbara	a Ross	Came	ron		
ary	shou and N s mai		19a. Informant's N	ame/Relations	hip (Type. Prin	nt)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	I Route Numb	er, City o	r Town,	State, Zip	Code)
Σ	and 2 ealth n 27 i		David 1	Hardin/	Son							Cour	t, Fair	cfax,	Vi	rgini	a 22032
ore	jes 1 t of H if iten or oth	- 1	20a. Method of Dis 1 🛛 Burial 2	•	3 ☐ Bernoval	I from State	20b. P	Place of Dispo cometery, crer	sition (Nan natory or o	ne of ther plac	e) ;	С	ate	20c. Lo	cation -	City or To	wn, State
Baltimore, Maryland 21215-0036	t. Pag tment tant: ijury e		4 ☐ Donation	5 ☐ Other (S	pecify)	Thom Oldio	G1	enwood					16, 2009				n, D.C.
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Nexical Examinar must be retilled at once.	jr 33	21. Signature of Fu	R. Bo	most		10154								kvil , Man	le,] ryland	Inc 20850
				rt failure. List	only one caus	e on each li	ne.			e of dyin	g, such as	cardiac o	or respiratory a	ırrest,			Approximate Interval Between Onset and Death
-	Physician / /Medical		Immediate Cause disease or condition resulting in death)	on	a			neumon	ia								2 Weeks
4	Examiner					ue to (or as	a consequ	uence of):									
	AP.	je	Sequentially list conditions, if any, leading to immediate cause. Enter U.S.rhyhy Cause (Disease or injury														
	cuted nd ransit	Examiner	Cause (Disease or that initiated events resulting in death)	injury	с												
,092	ate be executed hysician and the burial-transit		resulting in death)	Last	D	ue to (or as	a consequ	uence of):									
876	icate b physic the b	dical			d								·			-	
Box 6	Attending Physician: The law requires that the death certificate be executed r death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Med	IF FEMALE: 23b. Was deceden		23c. If ye	es, outcome	of pregna	incy							22d Dat	e of delive	ary.
B	death atter	ciar	in the past 12	months?	1 4	Live birth Pregnant a	2 Feta	death 3	Ectopic p Other (sp		/			1	Mo:		Day Year
P.O.	t the c by the ached	hysi	9 ☐ Unknown		9 🗆	Unknown							_				
S,	ires that the de signed by the a i be detached f	by P	Part II. Other signi	ficant condition	ons contributin	g to death b	ut not resu	ulting in the u	nderlying ca	ause give	en in Part I.		23e. Did	tobacco u	se contr	ribute to th	ne cause of death?
ord	w require s been si should b	ted											10	Yes 2	∑ No	3☐ Prob	ably 4 Unknown
ec	e law r has be	ple											24a. Was	psy	24b. V	Vere autoporior to cor	psy findings available mpletion of cause of
E H	: The cate I	S											perfo 1 ☐ Yes	ormed? 2 X No		leath? □Yes	2 🗆 No
Zit.	sician: The l certificate harector, page	Be	25. Was case refer examiner?		Hospital					Othe			(Check only				
o	Phys r this ral dir	٦.	1 ☐ Yes 2 ♣ 27. Manner of Deat			1 🔲 Inpatio		ER/Outpatier 28b. Time of		A	4 (A) NU		me 5 Res 28d. Describe				y)
on	nding Phy th. : After thi e funeral o	ţi	1 🕅 Natural 2 ☐ Accident	5 Pendin		Date of Inju (Month, Da	y, Year)	Injury	м	8c. Injury Work 1 □ \	? Yes 2 □ I		200. 20001130	now injury	Goodiii		
Division of Vital Records,	I or Attend after death. Director: /	ifice	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could i	not be ined 28e.	Place of Inj	ury - At ho	ome, farm, str	eet, factory	office		1	28f. Location (Street and	d Numbe	er or Rura	I Route Number,
Ö	tal or rs afte al Dir ed in	Certification: To	4 🔲 i loillicide			building, et	c. (Opecii)	y/					City of To	wn, state,			
H	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one)		g Physician: Examiner: Or and		f examina										
_	To the I within 2 To the I complet	Ź	29b. Signature and	tine of certifie	0 10	n	9	1	290	. License	e number			29d. Dat	e signed	(Month, I	Day, Year)
				ph	de /U	ulm	My	W		D192	294			Ma	rch	13,	2009
_			30. Name and add	Melnic		. 911	Rus	sell A	•	, Ga	ithe	rsbur	g, Mar	ylan	d 20	879	
	Sta Registr		31. Date filed (Mon	MAR 1	2009	32. Høgistr	-	ture Ø.	ark	ĵ							

		4	For State Registrar	State of Maryland /		tificate of	Death	F	Reg. No.	2009	08074					
	Physicia		1. Decedent's Name (First, Middle, Last) HARRY		HAR	219	2	Date of Dea MARCH	Day 12	2009	3. Time of Death 1:00 P M					
	/Medic	al .	4a. Facility Name (If not institution, give st	reet and number)	HAN	4b. City, Town, o	r Location of Death	11/11/07/		county of Death						
	LXamiii		LEVINDALE HEBREW			BALTIMOF If Under 1 Year		Data of Birth		N/A	le se (Ctata or Foreign					
	Funeral Director		5. Social Security Number 213-12-6564 Usual Residence of Decedent	M 2□F 7. Age (In yrs. last	Yrs.	Months Days	Hours Min.	Date of Birtl Month Day 08/09/	7921	9. Birmp Cour	place (State or Foreign of try) MD					
	yland now at		10a. State 10b. County	10c. City, To						1	0d. Inside City Limits 1 X Yes 2 No					
	e Mar Ba-f sh tiffed	Director	MD N/A		BALT	IMORE			10- Ohim	an of What Cour						
	with the	Dire	10e. Street and Number 2434 WEST BELVEDE	DE AVENUE		10f. Zip Code 212	215		_	en of What Cour USA	ntry?					
	ms 23	Funeral	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	13.		Hispanic Origin? (Speci an, Mexican, Puerto Ri	fy Yes or No-		4. Race - Americ Black, White,						
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No		oar, o	5	Specify: WH]	TE					
2-0	"natu "natu	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of working	'	16b. Kind	d of Business/In	dustry					
7	within iene. r than the Me	ошо	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		ORNEY				LAW						
b	al Hygi t other	Be C	17. Father's Name (First, Middle, Last)	110			18. Mother's Name (Maiden S	Surname) BLOC	ν					
<u>S</u>	should band Ment and Ment amarked umatic e	2	JACOB		RRIS		TILLY		er City or							
Maryland 21215-0036	nd 2 shoulth and 27 is m		19a. Informant's Name/Relationship (Type BEN KRUGER / GRI				COURT, REI									
Baltimore,	Pages 1 and inner of Health ant; If Item 27 ary or other trans.		20a. Method of Disposition 1 ☑ Buria 2 ☐ Cremation 3 ☐ R: 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place	e of Dispo etery, cre REW Y	osition (Name of matory or other pla OUNG MEN	Da (13)	- 1		ation - City or To						
altin	permit. P Departme Importani any Injur.		21. Signature of Fundral Service License	700	2	2. Name and Addre				& BROS.						
ä	Depar Impo any Ir		Tatukh.	James			STERSTOWN			SVILLE,						
		15	23a. Rant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. When Vas along Disease or condition a.													
	Physician /Medical		disease or condition resulting in death)	Due to (or s a consequen	ce of):	as who	Dirense				years					
	Examiner		Sequentially list conditions													
	P vis	iner	Sequentially list conditions, if any local process of the Underlying Cause (Disease or injury	Due to (or as a consequen	ice of):											
	execut n and al-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a consequen	ice of):		· ·									
68760,	tificate be executed ig physician and as the burial-transit	edical		l												
	ertifica ling ph e as th		IF FEMALE:	On 16 year authorms of programs	-						19					
.O. Box	w requires that the death cert been signed by the attending should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3	□Ectopic pregnanc □ Other (specify) _	су		2	3d. Date of deliv Month	ery Day Year					
<u>α</u>	requires that the een signed by th hould be detache	by Ph	Part II. Other significant conditions cor		-			23e. Did t	tobacco us	se contribute to	the cause of death?					
ords	equires en sig ould be	ed b	Afrensclenote	cardiovasc	lar	disease		1 🗆	Yes 2	X No 3∏ Pro	bably 4 □Unknown					
ecc	2 8 2	Completed						24a. Was		24b. Were autoprior to condeath?	opsy findings available empletion of cause of					
or Vital Records,	gate ⊒		25. Was case referred to medical				26. Place of Death	1□ Yes	21 21 No	1 ☐ Yes	2 No					
Ĭ.	S S	o Be	evaminer?	lospital: 1 ☐ Inpatient 2 ☐ EF	l/Outpatie	nt 3□ DOA Ot	ther: 42 Nursing Hom			☐Other (Spec	ify)					
o u		D: T	27. Manner of eath 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	8b. Time Injury	Wo	ork?	8d. Describe	how injury	occurred						
Division	Attending r death. ector: After by the fune	icati	Accident investigation 3 Suicide 6 Could not be	28e. Place of injury - At home	e. farm. s		Yes 2 No	8f. Location (Street and	d Number or Rui	al Route Number,					
Div	= <u>5</u> # c	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	,	,,		City or Tò	wn, State)							
2	To the Hospital within 24 hours a To the Funeral completely filled	edical C	29a. Certifier (Check only one) Certifying Phy-	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, dea n and/or i	th occurred at the nvestigation, in my	time, date and place, a popinion, death occurre	nd due to the	cause(s) , date and	and manner as place, and due	stated. to the cause(s)					
	To th To th	Me	29b. Signature and title of certifier	12/20			3943		29d. Date	e signed (Month	, Day, Year)					
	-(30. Name and address of person, who co	ompleted ause of death (Item 2	3at) (Type	, Print)	111111111111111111111111111111111111111	2 /	1	3.0						
		7	30. Name and address of person who constitution of the state of the st	evy, DD 1	Levi	volole 2	YSY W	xlue	sere	421)					
	St Regist	ate	31. Date filed (Month, Day, Year)	32. Hegistrar's Synatui	par											
	ricgisi	Tail	MAK 1 0 2003	1	,											

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			For State	State	of Maryla		partment of learning		d Mental Hy	200	Ω	00075
			Registrar	(ertificate of	Deam	1001 (0		7	00013
Ph	ysicia	an	Decedent's Name (First, Middle	e, Last)					2. Date of D		åro 9	3. Time of Death 9:43p M
-	Medic		TAYLER		HEFL	IN	45.00					9.43p ™
Ex	amin		4a. Facility Name (If not institution			_		or Location of De	eatn	4c. County of D		
			Freater Balting 5. Social Security Number	nore Med		Cente		OWSON If Under 24 F	rs. 8. Date of Bi	Baltin		ece (State or Foreign
	eral ector			1 XM 2 ☐ F	7.7 ngo (117 y	Yrs.	Months Days	Hours M	lin. (Month, D	Pay, Year)	Countr	y) ·
			infant Usual Residence of Decedent					3 8	3 2/28/0	9 Mar	ута	1d
ylanc yow	幅		10a. State 10b. County		10c.	City, Town or l	ocation				100	d. Inside City Limits
Mar s-f	朝	Director	Maryland		Ва	ltimore	9					1 ∏ Yes 2 □ No
h the	DU A	ire	10e. Street and Number				10f. Zip Code			10g. Citizen of What	Countr	y?
th wit	श्र	<u>a</u>	5922 Northwood	d Drive			21212			USA		
deal	E D	Funeral	11. Marital Status		edent Ever in	U.S. 13	. Was Decedent of	Hispanic Origin?	(Specify Yes or N	o- 14. Race - A Black, W		
after o	Đ.	F	1 XNever Married 2 Marr		2 XNo		1 ☐Yes 2 ☑No		icito rilodii, cto.;	Specify:		
ours a	ě.	d by	3 Widowed 4 Divorced	Year or I	Dates:			optony.				
72 h	dica	Completed	15. Decedent (Specify only highest	's Education et grade completed))	(Giv	edent's Usual Occu re kind of work done	during most of v	working	16b. Kind of Busine	ss/Indu	stry
vithin han	N N	E D	Elementary/Secondary (0-12)		1-4or 5+)		DO NOT use retire	?a)				
led v	臣		N/A 17. Father's Name (First, Middle,	N/A		N/A	A	19 Mathor's N	Jame (First Middle	N/A e, Maiden Surname)		
be f ed o	eve	Be	·	,					•			
Ital yiailid ZIZIS-UUSO 2 should be filed within 72 hours after death with the Maryland and Mentall Hygiene. Is marked other than "natural", or Items 23a or 28a-f show	Tatic	၉	THOMAS QUINTLY			405 14-5	(i.e., AII			RANSOM		
MICH d2sl than 7 is i	tra		19a. Informant's Name/Relations Greater Baltin		Ctr		N. Char			ber, City or Town, Stat		
St and 2 of Health of Item 27 is	ther	1	20a. Method of Disposition	note neu					Date	20c. Location - City	2120	
mit. Pages partment of portant: If it	ry or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 🛣 Other (S)		State	cemetery, ch	position (Name of ematory or other pla	ice)	Date	200. Education Only	01 1011	i, outo
permit. Pages 1 Department of H Important: If ite	any injury or other traumatic event, the Medical Examinar must be multiled at once.		21. Signature Funeral Service	. Wade	irecto					. Baltimore	e St	reet
		\dashv	23a. Part 1. Enter the disease, or	complications that	caused the de		altimore,			arrest,		Approximate
Dhari		. 1	shock, at heart failure. List Immediate Cause (Final	only one cause on	each line.		~ .	- 0			1 1	nterval Between Onset and Death
Physic	_		disease or condition resulting in death)	a. Dukto	(or as a cons	me	Johns	alul	47		-	
Exam	_											
		ē	Sequentially list conditions,	b	(ur as a ouns	equende of):						
uted	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
be exec	rial-tr		resulting in death) Last	Due to	(or as a cons	equence of):			·		\top	
cate be executed physician and	the burial-transit	dical		d								
	as #	ledi		1							T	
Attending Physician: The law requires that the death certificate that this certificate has been signed by the attending	for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	itcome of preg		Ectopic pregnan	cv		23d. Date of		
e dea	ed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of		Other (specify)			Month	D	ay Year
at th	should be detached	Ph	9 Unknown		1 A A A -			on in Dock I	OD- Did	Anh	4-4	
res th	peq	ģ	Part II. Other significant condition	ons contributing to o	leath but not n	esulting in the	underlying cause gr	ven in Part I.		tobacco use contribute		
requi	plnor	ted							- 1⊔	Yes 2∭ No 3 ☐	Probat	Jy 4∐ Unknown
e law has b	0.1	Completed							24a. Was	prior prior	autops	y findings available oletion of cause of
The Table I	page	် ဂ							perfo 1 ☐ Yes	ormed? death		
vician: The certificate	director, page 2	Be	25. Was case referred to medical examiner?						Death (Check only			
hysi	al dire	၉	1 ☐ Yes 2 💢 No				SIR OLIDOA		g Home 5 ☐ Res	idence 6 ☐ Other (S	pecify)	
ing F	funeral	ë	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date (Mor	of Injury 1th, Day, Year)	28b. Time Injury	Wor		28d. Describe	how injury occurred		
tend leath lor: /	the f	cat	2 Accident investig 3 Suicide 6 Could r	not be				Yes 2□No				
or At	in by	Certification:	4 Homicide determ	ned 28e. Place	e of Injury - At ling, etc. <i>(Sp</i> e	home, farm, s c <i>ify)</i>	treet, factory, office		28f. Location (City or To	(Street and Number or wn, State)	Rurai F	Route Number,
pital urs a	illed		29a. Certifier 1 🛛 CertifyIn	- Dhusisian To th	- h h - f l -		Alba a a a company of a filter of					
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A	oletely	Medical		Examiner: On the I	basis of exami nner stated.	nation and/or	investigation, in my	opinion, death o	ccurred at the time	e cause(s) and mannel , date and place, and c	lue to th	ne cause(s)
To the	comp	Ž	29b. Signature and title of certifier	(29c. Licens			29d. Date signed (Mo	nth, Da	ıy, Year)
			Malin					D39172		2/25/	00	}
7			30. Name and address of person	who completed cau	se of death (It	em 23a) (Type	, Print)			- 10)4/	-/	
			Ginny Werry				es Street	,Baltim	ore,MD 2	21204		
	Stat		31. Date filed (Month, Day, Year)	Ann s								
Re	egistra	ar	MAR 1 6 20	09	w p	- Agov						

TAYLER

上市区

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

an	State Registrar			Certific	ate of	Death		Reg. No.		0807		
	1. Decedent's Name (First, Middle, L	.ast)					Date of Dea Month	ath Day	year .	3. Time of Death		
al .	TYLER			HEFL			Februa					
	4a. Facility Name (If not institution, g		1 0	*	_	or Location of Deat	า		County of Death Baltim			
	Greater Baltime 5. Social Security Number 6.		(In yrs. last bir		TOW der 1 Year		8. Date of Birt			place (State or Fore		
	infant	1 □XM 2 □ F		Yrs. Mont		Hours Min.	(Month, Da)	y, Year)	Co	aryland		
ŀ	Usual Residence of Decedent								1,10	iryranu		
	10a. State 10b. County		10c. City, Towr	n or Location						10d. Inside City Limi		
	Maryland		Baltir	more						1 X Yes 2 □ N		
	10e. Street and Number			10f.	Zip Code			10g. Citiz	en of What Cou	intry?		
	5922 Northwood	Drive			21212	2		USA				
	11. Marital Status	12. Was Decedent Ev Armed Forces?		13. Was De If Yes, s	cedent of I specify Cub	Hispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	1	 Race - Amer Black, White 			
	1 Never Married 2 Married	If Yes, Give)		s 2√No	Specify:			Specify:	,		
	3 Widowed 4 Divorced	Year or Dates:	160	Decedent's U		notion		16h Kin	BJ d of Business/l	.ack		
1	(Specify only highest g	grade completed)		(Give kind of life. DO NO	work done	during most of wor	king	TOD. KIII	d of business/i	idustry		
	Elementary/Secondary (0-12) N/A	College (1-4or 5+)	N/A	Δ				N/A				
ľ	17. Father's Name (First, Middle, Las		124/1	*		18. Mother's Nar	ne (First, Middle,	/	Surname)	· · · · .		
	Thomas Quintl	ly Heflin				Lois	Anissa	Rans	om			
_	19a. Informant's Name/Relationship	(Type. Print)	19b	. Mailing Addr	ess (Street	and Number or Ru	ıral Route Numbe	r, City or	Town, State, Z	ip Code)		
	Greater Baltimon	re Med Ctr	6	701 N.	Char	les Stree	t Baltim	ore,	MD 21	204		
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☒ Other (Spec		20b. Place of cemeter	f Disposition (i ry, crematory o	Name of or other pla	ce)	Date	20c. Loc	ation - City or T	own, State		
13	21. Signature Funeral Service Lice School Sc	implications that caused the	ne death. Do i	Balti	more,	ess of Facility COMY Boar MD 2120 Ing, such as cardia	1		timore	Street Approximate Interval Between		
shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence %)										Onset and Death		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as a	consequence	of):								
١	Cause (Disease or injury that initiated events resulting in death) Last	C		.0.								
4	resulting in death, East	Due to (or as a	consequence (or):								
1	IF FEMALE:											
									3d. Date of deli	very Day Year		
	Part II. Other significant conditions	contributing to death but	Part II. Other significant conditions continuously to dearn but not resulting in the differential factor.									
	Part II. Other significant conditions	contributing to death but	The resulting in	- I alo undonyin			1 □ Y	es 2K	1NO 3 PR	bably 4 Unkno		
		s contributing to death but	The resulting in				24a. Was e autop perfor 1 □Yes	en sy med? 2 12 No	24b. Were aut prior to c death?	obably 4 ☐ Unknoopsy findings availal completion of cause of 2 ☐ No		
	25. Was case referred to medical examiner?	Mosnital:			Loui	2051	24a. Was e autop perfor 1 □Yes	en sy med? 2 1xt No ne)	24b. Were aut prior to c death? 1 □ Yes	opsy findings availa ompletion of cause o 2 □No		
for population of o	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☑ Inpatient	t 2□ER/Ou	itpatient 3 🗍	DOA Oth	ner: 4 🗆 Nursing H	24a. Was e autop perfor 1 □ Yes ath (Check only or	en sy med? 2 12 No ne)	24b. Were aut prior to c death? 1 ☐ Yes	opsy findings availal ompletion of cause o 2 □ No		
for population of o	25. Was case referred to medical examiner?	Hospital: 1 ☑ Inpatient 28a. Date of Injury (Month, Day)	t 2 □ ER/Ou		DOA Ott	ner: 4 ☐ Nursing H	24a. Was e autop perfor 1 □Yes	en sy med? 2 12 No ne)	24b. Were aut prior to c death? 1 ☐ Yes	opsy findings availa ompletion of cause of		

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ginny Merryman, M.D.,
31. Date filed (Month, Day, Year)
NAR 1 6 2009 6569 N.Charles St., #501, Baltimore, MD



State Registrar

D39172

21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** NELSON R. IZQUIERDO 3:00 2009 MARCH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner COPPER RIDGE SYKESVILLE CARROLL Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 € M 2 🗆 F Months Days Hours Min. 83 Director 9/11/1925 PUERTO RICO 581-68-6941 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 'natural'', or items 23a or 28a-f shov digal Exercitant reunt by continued at Director 1 ☐ Yes 2 No MD CARROLL WESTMINSTER 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 708 CHARINGWORTH CT. 21158 USA **Funeral** 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No 1 9 4 6 — 14. Bace - American Indian 72 hours after 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 X Yes 2 ☐ No Specify Specify: WHITE 2 3 X Widowed 4 □ Divorced 1976 PUERTO RICAN Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) SOLDIER MILITARY 12 d 2 should be filed with and Mental Hygier Prismarked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LUIS IZQUIERDO FEBO MARIA မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a
Important: If item 27 is
any Injury or other trau 708 NELSON IZQUIERDO SON CHARINGWORTH CT., WESTMINSTER, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST VETERANS C 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation OWINGS MILLS, MD CEM 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal my of For eral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** mentle disease or condition resulting in death) Pars /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami and the burial-tran Due to (or as a consequence of) physician Box 68760 law requires that the death certificate be Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 2 □No 2 🗷 No 1 🗆 Yes Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

P.0. Division of Vital Records,

Registra

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, State

Medical

29a. Certifier

(Check only onel

29b. Signature and title of certifie

MI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

6

29d. Date signed (Month, Day, Year) 0

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Marc one rainia /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GEORGES OF Ge 6. Sex In yrs. last birthday) 8. Date of Birth (Month, Day 9. Birthplace (State of Foreign Social Security Number 7. Age **Funeral** Hours Months 1 □ M 2 X F Yrs Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 💢 No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🏋 No Specify: þ 3 ☐ Widowed 4 X Divorced ac Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Howard d Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ 19a. Informant's Name/Relationship (Type. Print) (SISTER 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 270 Floor 20c. Location 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 12009 1 Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee W. Russ Lunersy Ave. By 23a. Part f. Inter the discusse, or complication: that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardio-respirator disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cardiac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Physician: The law requires that the death certificate be executed Years End Stage Disease Kenal Due to (or as a consequence of): P.O. Box 68760, HIV IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 X No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 XNo 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0061825 2TC

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Greenway

Drive

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

09-01868 Josephine Kellman		ent of Health and Mental Hygiene	gible.
h	Registrar	cate of Death 2. Date of Dea	Reg. No. 2003 UOU1
Physician/ Medical Examine		Month March 5,	Day Year account
V -	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
f	1227 North Montford Avenue	Baltimore	NIA
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last bit	rthday) If Under 1 Year If Under 24Hrs. 8. Date of Bi	irth (MM/DD/YYYY) g. Birthplace (State or Foreign Palm Basch Country)
Director	Usual Residence of Decedent	4 Yrs. July	10,1944 Country) Flordia
any some some some some some some some some	10a. State 10b. County 10c. City, Town	n or Location	10d. Inside City Limits
MO NO	MD NA	Baltimore	1 Ves 2 No
death with the Maryland riems 23a or 28a-f show must be notified at once.	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
- E # # L		2/2/3	lo- 14. Race - American Indian, Black,
or items 23	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 	White, etc.
_		1 Yes 2 No specify:	Specify: Black
oursafte	15. Decedent's Education (Specify only highest grade completed) 16a	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
5-0036 led within 72 hour lygiene. other than "natu the Medical Exar	Elementary/Secondary (0-12) College (1-4 or 5+)		Dusiness Aubia
5-003 led within tygiene, other th	17. Father's Name (First, Midgle, Last)	House Reeping 18. Mother's Name (First, Middle	Business Owner, Maiden Surname)
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica		Mildred	Wilkerson
e, MD 21215-0036 1 and 2 should be filled within 72 hours Health and Mental Hygiene. Transmatic event, the Medical Exam To Be Completed	19a. Informant's Name/Relationship (Type, Print)	9b. Mailing Address (Street and Number or Rural Route No.	umber, City or Town, State, Zip Code)
e, MD 2 and 2 shou Health and N item 27 is r	Bonnie Davis - daughter 11		120c. Location - City or Town, State
5 2 2 E P		e of Disposition Name of cerhetery, Date atory or other place)	20c. Location - City or Town, State
Baltimore, pemit Pages I an Department of Hee Important: If ite injury or other tr	4 Donation 5 Other Speaify:	Zion 3/13/09	Baltimore, MD
Balt Sermit Depart Impor	21. Signature of Funeral Servic Licensee	22. Name and Address of Facility Howell F 3331 Brehms Lane	uneral Home Baltimore, MD 21213
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do	not enter the mode of dying, such as cardiac or respiratory a	rrest, shock, or heart Approximate Interval
Medical	failure. List only one cause on each line. Immediate Cause (Final disease a. Intracerebral		Between Onset and Death
`xaminer	or condition resulting in death) Due to (or as a consequence of):		
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
	cause. Enter Underlying Cause. (Disease or injury that initiated		
lisit 😭	events resulting in death) Last Due to (or as a consequence of):		
and scut	0. DTT 2	7,permE, g889 3/20/09 TT	
60, te be of hysicia	IF FEMALE: 23c. If yes, outcome of pregnance		23d. Date of delivery
Box 68760, re death certificate be ex- the attending physician red for use as the burial.	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregnancy	Month Day Year
OX 6	4 Pregnant at time of death 1 Yes 2 ✔ No 9 Unknown g Unknown	5 Other (Specify)	
that the de	Part II. Other significant conditions contributing to death but not result	ting in the underlying cause given in Part I. 23e. Did	tobacco use contribute to the cause of death?
P.C es that igned be deti	Hypertensive cardiovascular di	sease 1 T	res 2 No 3 Probably 4 ✔ Unknown
Livision of Vital Records, P.O. tell or Attending Physician: The law requires that the rafter death. "al Director: After this certificate has been signed by lied in b, the funeral director, page 2 should be detach.	Hypertensive cardiovascular di	24a. Wa aut	as an 24b. Were autopsy findings available prior to completion of cause of
eco ne law te has ige 2 s			formed? death? s 2 No 1 🗸 Yes 2 No
m: T		26.Place of Death (Check only one)	
Vits of this of	25. Was case referred to medical examiner? 1 Ves 2 No 288 Date of Injury 288	/Outpatient 3 DOA Other Nursing Home 5	Residence 6 Other: Scene
of Vital Recling Physician: The I		b. Time of Injury 28c. Injury at Work? 28d. Describ	e how injury occurred
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or A after	3 Suicide 6 Could not be determined (Specify)	, farm, street, factory, office building, etc. 28f. Location or Town	
Mospita 24 hours Funeral	4 Homicide (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, and the specific forms and the specific forms are considered to the specific forms and the specific forms are considered to the specific forms and the specific forms are considered to the specific forms are considered	death occurred at the time, date and place, and due to the ca	ause(s) and manner as stated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwittin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	1 X Natural 5 Pending Investigation 28e. Place of Injury - At home determined (Specify) 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/cand manner stated.	or investigation, in my opinion, death occurred at the time, da	te and place, and due to the cause(s)
or Sor	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	landle Justhall mo	O.C.M.E.	March 6, 2009
	30. Name and address of person who completed cause of death (Item 23:		
	Pamela E. Southall, MD Assistant Medical Examin		
Sta	te 31. Date filed (Month, Day, Year) Z. Registrar's Signature ar	parle	
Registr	MAK = O COOO ALANDA	<u> </u>	

			For	State of Ma	aryland /		artment of H		nd Mer	ntal Hy	giene	2009	080	าลก
			State Registrar	l not)		Cei	rtificate of L	Death	2	Date of Dea	Reg. No.		3. Time of I	
	Physicia		Decedent's Name (First, Middle, I	Regina	Mary	K	imbel			Month March	Day	Year 2009	11:25	A M
	/Medic Examin		4a. Facility Name (If not institution, g	give street and number)			4b. City, Town, or	Location of	Death			County of Deat	h	
_			Light House Assi				Essex If Under 1 Year	If Under 24	4 Hre I o	Data - (Blad) 	Baltimo	ore Co.	Foreign
	Funeral Director		5. Social Security Number 214–26–6901	. Sex 7. Ag 1 □ M 2√2 F 8	e (In yrs. last i 1	Yrs.	Months Days	Hours	Min. De	Date of Birl (Month, Da ec • 8	y, Year) 192	27 Mai	nplace (State of untry) Cyland	roreign
			Usual Residence of Decedent		T								10d. Inside Cit	. Limita
	arylar show	'n	10a. State 10b. County		10c. City, To	own or Lo		1_					1 □Yes	1
	the M	Directo	Maryland Bal	timore			Dunda1	K			10g. Citi	zen of What Co	untry?	
	3a or	al Di	4 Midway Avenu	е				21222			Uni	ited Sta	ates	
	ems 2	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Decedent of H If Yes, specify Cuba	ispanic Origi an, Mexican,	in? (Specify Puerto Ric	y Yes or No an, etc.)	-	14. Race - Ame Black, White		
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, Ite Product Examinar must be notified at once.		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	d 1 □Yes 2√□ I If Yes, Give Year or Dates:	No		1∐Yes 2X 3XNo	Specify:				Specify:	√hite	
2-003	2 hour	ted	15. Decedent's	Education	16	6a. Dece	dent's Usual Occup	ation	af warking		16b. Kii	nd of Business/		
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2	shoul ind Mi is mark umati	악	19a. Informant's Name/Relationship		1	9b. Mailii	ng Address (Street	and Number	r or Rural R	loute Numb	er, City o	r Town, State, 2	Zip Code)	
Ž	and 2 ealth a n 27 is		Mr. Thomas Kiml	bel (Son			Bayside :			dalk,			21222	
OCE	ges 1 t of He If item or oth		20a. Method of Disposition 1⊠ Burial 2 □ Cremation 3	□ Removal from State			sition (Name of matory or other plac		Date			cation - City or		1
апппо	it. Pag rtmen rtant: njury		4 ☐ Donation, 5 ☐ Other (Spe 21. Signatur — uneral Service Lic		Gard		of Faith						Maryla	ınd
ם	permi Depar Impor any Ir		21. Signaturi Funeral Service Lie	Eleny			2. Name and Addre Ouda-Ruck 7922 Wise							
				omplications that caused	d the death. D							Tana 21	Approximate Interval Betv	veen
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1	/Medical Examiner		resulting in death)		a consequence	ce of):								
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л Э	nat the d by th etache	Phys	9 Unknown Part II. Other significant condition		out not recultin	a in the u	inderlying cause give	en in Part I		23e Did t	ohaccou	use contribute to	the cause of d	eath?
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S	law requas been 2 shoul	letec								24a, Was	an	24b. Were au	topsy findings a	available
VItal Records,	The la	Completed								auto perfo 1 □ Yes	psy ormed? 2XINo	prior to death? 1 □ Yes	completion of ca 2 □ No	ause of
Ī	cian: ertifica ctor, p	BeC	25. Was case referred to medical examiner?				I -			Check only o	one)		1001	sted
5	Physia this c		1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpati 28a. Date of Inji	ent 2 ER	Outpatie				5 Resi			cify) Livi	ng
0	ding th. After funer	tion	1 X Natural 5 Pending 2 Accident investiga	(Month, Da		Injury	Wor	k? Yes 2∐N		1. Describe	now mjur	y occurred		
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	1 0		•	YW - 3	(A)	2 14	DO DO	061907	7		Mar	ch 10,	2009	
<	Ÿ		30. Name and address of person w		death (Item 23			ltimo:	re. Ma	arylar	nd 2	21221		
	Sta	ate.	Chukwuma Ebo, 31. Date filed (Month, Day, Year)	22 . Regist	rar's Signature	-								
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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 19:27 March 3,2009 Jessie Wiggins Littleford /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George 7. Age (In yrs. last birthday, Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Director 579-46-3843 May 19,1937 Whitakers, NC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-1 shov any injury or other traumatic event, Il wedical Examiner must be notified at 1**X**Yes 2 □ No Directo District of Columbia Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20020 United States 2506 23rd Street SE 12, Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 2 If Yes. Give 1 ☐ Yes 2 Total o Specify Specify: Black 3 ₩ Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) The Library of Elementary/Secondary (0-12) College (1-4or 5+) Twe1th Restorer Congress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jimmie Wiggins Ola Tucker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phillip Littleford/Son 11702 Thrift Rd., Clinton, Maryland 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Spacify) March 10. Ft Lincoln Cemetery Brentwood Maryland 22. Name and Address of Facility Robert G. Mason Funeral Home Inc 21. Signature of Funeral Service Li Daniel W. Harrison 1661 Good Hope Rd SE, Washington DC 20020 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** antenou disease or condition resulting in death) /Medical Due to (or as a consequence of): DiSunse Examiner Saguritally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed and burial-tran Due to (or as a conséque physician a Box 68760 Physician/Medical use as t attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery death 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a d be detached for Ö 9 Unknown σ, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 certificate of Vital 1 □ Yes 1 ☐ Yes 2 No 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 24 ER/Outpatient 3 DOA Certification: To this funeral 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division or Attending 1 Natural 5 Pending investigation Injury hours after death.

neral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours To the Funeral 29a. Certifier 1 Certifying Physiolan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) Medical Examiner: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and

Name and address of

31. Date filed (Month, Day,

son

title of certifie



29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2045 M Physician Langford Robert 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Niconico SALISBULL MESICAL REGIONAL If Under 1 Year | If Under 24 8. Date of Birth (Month, Day, Year) March 31,1940 Birthplace (State or Foreign Country) . Age (In yrs. last birthday) Social Security Number **Funeral** Days Hours Min 219-26-9494 Maryland 68 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 ☐ Yes 2 ☐XNo Selbyville Director Delaware Sussex 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 19975 USA 30751 W. Stoneyrun Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 1 Never Married 2 Married 1 □Yes 2 🛣No If Yes, Give Year or Dates: Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Produce Manager 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Agnes Marie Polacak Elrov Carl Langford ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum once. 30751 W. Stoneyrun, Selbyville, De. 19975 wife Patricia Langford 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Marchatel 4, 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Memorial Middle River, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. wtho 21222 23a. Part1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancer Esophogeal **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner premo Sequentially list conditions, if any leading to immediate Due to (or as a consequence of) Examiner if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death

9 ☐ Unknown 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 Natural 1 □Yes 2 □No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be

requires that the death certificate be executed Box 68760. P.O. |

physician and the burial-trans

attending p

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

d 2 should be filed within 72 hours after death with the Maryla th and Mantal Hyglene. A 7 is marked other than "natural", or items 23a or 28a f show traumatic event, it is "not all Expressed out the than "natural".

28a-f show

been signed by the should be detached Division of Vital Records, has page 2 certificate l funeral director, this After t To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft. the 1 completely filled in by

> State Registrar

DHMH 17 Rev 1/2001

3 Suicide

29a. Certifier (Check only one)

29b. Signature ai

30. Name and address of person

CHRISTOPHER SNY DER 31. Date filed (Month, Day, Year)

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

(45049)

29d. Date signed (Month, Day, Year)

St. SAlisbury Md 21801

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

who completed cause of death (Item 23a) (Type, Print)

Registrar's Signa

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 08084 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 6, Elizabeth March 2009 Anna Lowe 8:00AM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Lutherville College Manor Baltimore 8. Date of Birth (Month, Day, Year)
Oct. 28,1918 If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🗓 F 90 Director MD <u>218-32-0218</u> Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner crust be notified at 1 ☐ Yes 27 No Directo Baltimore Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3703 Old Milford Mill Road 21244 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: 2 3 X Widowed 4 □ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be flik Department of Health and Mental Hy Important: If Item 27 Is marked othany Injury or other traumetic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Barbara J. Vassold ٩ Henry J. Schenning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son 1304 Buckhorn Road, Sykesville, MD 21784 George Lowe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/9/09 Woodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road sus Eline Funeral Home 21136 Reisterstown, MD 23a-Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) a VASCULAR DEMENTIA Examiner Examiner CARDIOVASCULAR physician and as the bunal-transit ARTERIOSCIEROTIC The law requires that the death certificate be executed Box 68760. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Due to (or as a consequence of): use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed b þ 24b. Were autopsy findings available prior to completion of cause of death? page 2 should Completed 24a. Was an autopsy performed? has 2 No this certificate 1 🗆 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred LIVING 28c. Injury at Work? After 1 Natural 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide hours after within 24 hours a
To the Funeral I
completely filled Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I 29c. License number 29b. Signature and title of pertifier 29d. Date signed (Month, Dey, Year) Cugarisone MD D16619 march 6, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9940 FRANKLIN SOUARE DR. NOTTINGHAM NO. 21239

State Registrar

31. Date filed (Month, Day, Year) MAR 1 6 2009

·VERGARA-SOARES

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3 2009 Mari 8+07PM **Physician** Alberta Lane March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Bu It ilrove Hurbor N/A Birthplace (State or I Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 7 F 2/7-46-37/1 Usual Residence of Decedent Director 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examination is the notified at 1 ☐ Yes 2 No Director MD. CO GLEN BURNIE A . A . 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6434 ROOTS DRIVE 21061 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: BLACK ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) STATE OF MD Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY TRANSPORTATION 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental CLYDE MACKELL ALBERTA GROSS ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any injury or other trau once. REGINALD 6434 ROOTS DR. GLEN BURNIE, MD. LANE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ other (Specify) ST. REST CEM. 3/20/09 DORSEY, MD. A.A.CO 21. Silver of Funeral Septice Licenses 22. Name and Address of Facility BALTO.MD PL.21217 ESTEP BROS.F.H.P.A. 1300 EUTAW Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Paute uspirotory **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner 2 worth Brain Metastur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transi Endomaria ré4VJ CHINCED Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 □Yes 2 □ No s been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by fibrillation Atriul 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 1 per tension 24a. Was an cate has b 1 ☐ Yes 2 ☐ No 2 □ № ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Unitural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

State Registrar

31. Date filed (Month, Day, Year)

11/0/2

29b. Signature and title of certifier Lawriet Two

Cashiel



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

RES 001

steet

29d. Date signed (Month, Day, Year)

March 13 2009

Buttimore, MP 21225

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician LASSITER RICHARD 7:30 PM MARCH 04 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE HOSPITAL HARBOR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Nov 18, 19 9. Birthplace (State or Foreign Country) Social Security Numberunk | 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 M 2 □ F unk 1954 54 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a ~ any injury or other traumatic event. The Market and India? 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 No MD Baltimore Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 22 S. Athol Avenue 21229 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.**31nk** 13. Was Decedent of Hispanic Origin? (Specify Yes or No Armed Forces? unk 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No þ Specify: black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk Elementary/Secondary (0-12) College (1-4or 5+) unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3000 S. Hanover Street Baltimore, MD 21225
ce of Disposition (Name of Date 20c. Location - City or Town, State Harbor Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 NOther (Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Wade, Director 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 12222 Baltimore, MD 23a. Part I. Enter the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C e (Final disease or condition resulting in death) DISSEMINATED CRYPTOCOCCAEMIA Physician MONT /Medical Due to (or as a consequence of): Examiner DEFICIENCY SYNDROME IMMUNE UNKOUN QUIRED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospitator Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE: If yes, outcome of pregnancy
↑ ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by INSUFFICIENCY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 □ Yes 2 No 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death.

I Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aff

To the Funeral Di

completely filled in 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) law M. D RES -001 MARCH 04 2009

State Registrar

MAR 1 0 ZU

31. Date filed (Month, Day, Year)



HARBOR HOSPITAL, 3001 SOUTH HANOVER STREET, BALTIMORE,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MINOVITZ, DEBORAH

			For State Registrar	State of Marylan	•	artment of F rtificate of t		Ť	giene Reg. No.	200	9 0808	
			Decedent's Name (First, Middle, Las	t)				2. Date of Dea	ath		3. Time of Death	
	Physicia		Deborah Ann Minov	itz				MArch	Day	2 00	9 9:42AM	
-4	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Dea		4c. C	ounty of Deat	h	
أرس			Doctor's Communit	y Hospital		Lanham			Pri	ince Ge	orge's	
	Funeral		Social Security Number 6. Se	TAL OVE		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da	y, Year)	Co	hplace (State or Foreign untry)	
	Director		218-74-9743	52	Yrs.			Sep. 13	, 195	66 Mai	ryland	
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	cation					10d. Inside City Limits	
	Mary -f sh	to	Maryland Prince	George's Lar	nham						1 X iYes 2□No	
	r 28a	irec	10e. Street and Number	ocorge 5 Lar	man	10f. Zip Code			10g. Citize	n of What Co	untry?	
	h with	a D	8503 Redwing Lane			20706			USA			
	filed within 72 hours atter death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiran must be meilfied at	by Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	ispanic Origin? (an, Mexican, Pue	Specify Yes or No	- 14	I. Race - Ame Black, White		
36	or it	y F.	1 Never Married 2 Married	1 □Yes 2 XNo If Yes, Give		1□Yes 2XINo	Specify:	,	s	necify:		
Ö	hours 'ural'	q p	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	160 Door	dent's Usual Occup	otion			of Business/	lite	
7	in 72 "nat	olete	15. Decedent's Ed (Specify only highest grad	de completed)	(Give	kind of work done of DO NOT use retired	durina most of wo	orking	IOD. KING	O Dusiness/	moustry	
21215-0036	withing inene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Manas	ger	,		Reta	ail		
ğ	othe Jent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle,	Maiden Si	urname)		
/lar	uld by Menta arked	To	Allen Minovitz				Patrici	ia Ann Le	nt			
Maryland	2 sho and is ma		19a. Informant's Name/Relationship (7	ype. Print)	19b. Mailir	ng Address (Street	and Number or F	Rural Route Numbe	er, City or 1	Town, State, 2	Zip Code)	
2,	and fealth m 27 her tr		Allen Minovitz/ F			Redwing	Lane Lar					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examiration and the notified at once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, crei	sition (Name of matory or other place NONT	re)	Date		ation - City or		
ξ	it. Pa rtmer rtant: njury		4 □ Donation 5 □ Other (Specify) Mer	norial	Gardens	3/1/				le, MD	
Ba	permi Depar Impo any ir		21. Signature of Funeral Service Licen	6ee		2. Name and Addre 6000 Anna					ral home	
		-	23a. Part 1. Enter the disease, or comp	lications that caused the death						20713	Approximate	
	Physician		shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.	1.	1-1	InA	1)	Interval Between Onset and Death	
-	/Medical		disease or condition resulting in death)	a. Due (or as a consequ	uenze of):	andiai	// PCA	verien		1 hour		
	Examiner		On any and the line and disease	Corone	wy ,	Intor	VDI	spase			Un Chain	
	D ti	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Que to (or as a consequ	uenge of):	, , ,					1. 1	
<	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Du (or as a consequ	nSil	20					Con Known	
8760,	ficate be executed physician and s the burial-transit	al E	and the state of t	Duy (or as a consequ	derice or).							
	ficate phys s the	edical		d.						1		
9 x c	nding se a	M/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		.000			23	d. Date of del	iverv	
Box	death e atte d for u	iciaı	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		☐ Ectopic pregnanc ☐ Other (specify) _	у			Month	Day Year	
P.0.	t the by th	Physician/Me	9 ☐ Unknown	9 🗆 Unknown			<u> </u>	Τ.				
S,	The law requires that the death certifiate has been signed by the attending age 2 should be detached for use as	by P	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the u	nderlying cause giv	en in Part i.	23e. Did t	obacco use	1	the cause of death?	
pio	equir	ted	_ () besiny					- 10	Yes 2□	No 3PPr	obably 4 Unknown	
Ö	e law r has bo e 2 sh	Completed	/					24a. Was autor	osy	24b. Were au	topsy findings available completion of cause of	
<u> </u>	: The cate	Con						perfo 1 □ Yes	rmed? 2 DNNo	death? 1 ☐ Yes	2 □ No	
Ĭ.	i lclan : Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth	or.	eath (Check only o				
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Division of Vital Records,	il or Attending Physician: after death. Director: After this certific d in by the funeral director,	ifica	3 ☐ Suicide 6 ☐ Could not be determined	20e. Place of injury - At ho	me, farm, str	eet, factory, office		28f. Location (Street and	Number or Ru	ural Route Number,	
ō	tal or rs afte al Dir ed in	Certification: To	4 (tottilicide	building, etc. (Specif	y/ 			City or Tox	wii, siate)			
	To the Hospital or Attending Physician: The within 24 Hours after death. To the Funeral Director: After this certificate h. completely filled in by the funeral director, page		(Check hiy 2 Medical Exam	ysician: To the best of my kno liner: On the basis of examina								
+	To the H within 24 To the F complete	Medical	one)	and manner stated.								
	5 5 5 G	-	29b. Signature and title of certifier	lev.		29c. Licens	o number	nal	Zau. Date	signed (Monti	G (Gar)	
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			30. Name and Address of person who	VK MIO Dock	ZOU) (IYDE,	many k	then to	18118	frond	link.	ld Lankan Mr	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture		1 May 1	0//0			1	

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien (1) (1) Samend Items 23aPtI, 25, 27, 28a-fin Dec (1) 9 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year MASSINGALE **Physician** AUREL 1:21 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Maryland Medical Center Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Hours Months Days 1 □ M 2 T F 217 36 5297 0klahoma Director 09/17/1939 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Evantian must be mailed at 1 ☐ Yes 2√☐ No Director Anne Arundel Lothian Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 979 Margita Street Rio Vista Plaza 20711 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ 3 ☐ Widowed 4 K Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrator U.S. Military 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Laurie Smith Mary Miller မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 539 Matthews Avenue Baltimore, Maryland 21225 Scott Harman / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Department of Important: If it any Injury or o 1 ☐ Burial 2 🖫 Cremation 3 ☐ Removal from State 02/19/2009 | Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature a Fun ral Service Lic 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AML **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner subdural hematoma CERTIFICATION APPROVED BY MEDICAL EXAMINER cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 bacteremia IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Vear 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Onknown 1 🗌 Yes Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 1NO Medical Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Unknown within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Unknown M 1 ☐ Yes 2 K No investigation Unknown 2 Accident 6 XX uld not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Unknown 4 ☐ Homicide Unknown 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number UNP # 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Feb 15, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Greene St. Baltimore MD 21201

Registrar

31. Date filed (Month, Day, Year)

M.L.



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mc Manus 12:25.AM Nilber March 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) ace (State or Foreign Min. -18 1 M 2□ F Months Days Hours -58 (aro Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No nd. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ocialed Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) aborer

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

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BaiTmore, MD

Physician /Medical Examiner For State Registrar

10a State

17. Father's Name (First, Middle, Last)

CYNTHIA

MAR 1 6 2009

31. Date filed (Month, Day, Year)

Bette

19a. Informant's Name/Relationship (Type. Print)

Funeral Director

Completed by

Be

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Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinat must be writiful at once.

Baltimore, Maryland 21215-0036

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attending physician and for use as the burial-trar signed by the

The law requires that the death certificate be cate has l this certificate the Hospital or Attending Physician: director, After thi funeral within 24 hours after death

To the Funeral Director:
completely filled in by the f

Division of Vital Records,

ASSociated way McManus Apt 404 mo, 2111 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Surial 2 ☐ Cremation 3 ☐ Removal from State -20-09 4 Donation 5 Dother (Specify) 21. Signature of Fune 1 Service Lice FIT 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Concer Prostate MetasTAlic 15 years disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 💥 Unknown Mell.Tus 24b. Were autopsy findings available prior to completion of cause of death? Diabelles autopsy performe Dement.A 2 No 2 **N**No 1 ∐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 1 Yes 2√No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D.O. 03-12-2009 H0062554

DHMH 17 Rev 1/2001

State

Registrar

838

NOETH

30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

		For State	-	epartment of Health and N		711114	nenen
-		Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of Death	Reg. N		3. Time of Death
Physici		JOF N. M.	90/1/5/-		Month E	2 14 Year 2009	0100 M
/Medic Examir		4a. Facility Name (If not institution, give st	reet and number)	4b. City, Town, or Location of Death		c. County of Death	
at the same of the	ш	5. Social Security Number 6. Sex	MM/AWES!	nday) If Under 1 Year I If Under 24 Hrs.	8. Date of Birth	PALIMON	E_ O (State or Foreign
Funeral Director			7. Age (In yrs. last birth	rs. Months Days Hours Min.	(Month, Day, Yea	2/) 9. Bit inplact	e (State or Foreign) 30 NN A
7		Usual Residence of Decedent			110010110		W///
arylar show	7	10a. State 10b. County	10c. City, Town) 0 0 1		10d.	Inside City Limits 1 ☐ Yes 2 ▼No
the M 28a-f	rect	10e. Street and Number	noie 1	10f. Zip Code	10g. (Citizen of What Country?	
72 hours after death with the Maryland 72 hours after death with the Maryland inatural", or items 23a or 28a-f show deal Exact met be readily of at	Funeral Director	9109 Liber	y Road	21133		USA	
r deat	nner	11. Marital Status	2. Was Decedent Ever in U.S. Armed Forces? 1 Xes 2 ☐ No	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - American Black, White, etc.	Indian,
rs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 □ No If Yes, Give Year or Dates:	1 □Yes 2 No Specify:		Specify: 3	tack
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al ylallo ZIZ should be filed withi nd Mental Hygiene, s marked other than umatic event, than	To Be			ink.			unk.
2 shour and he is ma		19a. Informant's Name/Relationship (Typ		Mailing Address (Street and Number or Ru			
T, IV 1 and Health Sm 27 ther tr		Timoffy Li Hub	bard-nepher 4	Disposition (Name of	Date 20c.	nd manor, 1 Location - City or Town,	State /
partilliore, Marylaria AIAIS-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, the Wedgel Exp. in act will be notified and		1 Surial 2 ☐ Cremation 3 ☐ Re	/ \ camatari	, crematory or other place)	18-09 (rouns Jille	
permit. P Departme Importan any injur		21. Signature neral Service License	1	22. Name and Address of Facility	70 Fred	HILTM	Pass
Dan permi Depar Impor any ir	W B	JMY /1 /1/1/1	M	Vary Pimarch	FIH. BO		.21229
		shock, or neart failure. List only one	ations that caused the death. Do no cause on each line.	ot enter the mode of dying, such as cardiac	or respiratory arrest,	Ap Int Or	oproximate terval Between nset and Death
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Examiner			Due to (or as a consequence o	7			
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xecute and II-trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequence or	f):			
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the de	ysic	1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)			
s that gned be e deta	by Pi	Part II. Other significant conditions cont	ributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the c	ause of death?
w requires to the second of th	ted				1 ☐ Yes	2 No 3 Probabl	y 4 Unknown
e 2 sh	Completed				24a. Was an autopsy	24b. Were autopsy prior to compledeath?	findings available letion of cause of
VILAIF ician: Th sertificate ector, pag		25. Was case referred to medical		00 Plan of Page	performed		No
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Attending ar death. ector: Afte by the fune	icatio	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	200 Place of Injury At home for	M 1 ☐ Yes 2 ☐ No	206 Location (Otro-1	- d Number on David B	
lor A after a Direc	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At home, fare building, etc. (Specify)	m, street, lactory, office	City or Town, Sta	and Number or Rural Re ate)	Sute Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit				death occurred at the time, date and place d/or investigation, in my opinion, death occu			
the H hin 24 the Fu	Medical	one)	and manner stated.				
vit Vor		29b. Signature and title of certifier	Bruton (1)	29c. License number H 45931	Λ/	Date signed (Month, Day larch 12 ^{'HI}	12000
		30. Name and address of person who cor	npleted cause of death (Item 23a) (0 ;	MINICALLE	
		Dr. Debble Bi	rton 283	5 Smith Avonue	Baltin	nore MI)	21209
Sta Regist		31. Date filed (Month, Day, Year)	732, Hegistrar's Signature	all			,
		MARIOZOUS	Mr.				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 03/ 10/ Day 9 9:25P M Khadija Α. Mohamud 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Charles Indian Head 5034 Black Shaw St. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 1 1 / 2 1 / 1 9 6 0 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1 M 2 F Months Somalia 48 223-55-7444 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Charles Indian Head 1 ☐Yes 2 ☐No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20640 USA 5034 Black Shaw St 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2**X** If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Housewife Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Fadumo A. Mohamud Mohamud Δli 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Abdi Mohamed / husband 7905 13th St NW, Washington, DC 20012 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Murial 2 ☐ Cremation 3 ☐ Removal from State 3/13/09 All Muslim Ceme. Stafford, VA 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Universal Mortuary Inc. 21. Sig sture f Funeral Service Licensee 411 Kennedy St. NW, Washington, DC 20011 23a. Part 1. Englethe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter the certific Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

28a-f shov

Director

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Completed

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modest Exercises cust be mortified at

72 hours after death with

d 2 should be filed within the and Mental Hygiene.
7 is marked other than "r

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once.

3altimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

Attending Physician: The

To the Hospital within 24 hours a To the Funeral L

/Medical

law requires that the death certificate be executed

Examiner s been signed by the attending physician and should be detached for use as the burlat-trans Physician/Medical Completed by certificate has birector, page 2 sh director, Be Certification: To After this spital or Attending Phy hours after death, ineral Director; After this y filled in by the funeral di

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

5 Pending investigation

6 ☐Could not be

determined

25. Was case referred to medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1 Yes 2 No

examiner?

27. Manner of Deal

1 Natural

2 Accident 3 Suicide

4 ☐ Homicide

29a. Certifier (Check only 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

1∐Yes 2NNo 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 70

28a. Date of Injury (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Medical



1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 06:44 a™ **Physician** March 12, 2009 Gloria DeLuca McCormick /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Gilchrist Center for Hospica Care Towson If Under 24 Hrs. I Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 06/08/1925 . Age (In yrs. last birthday) 5. Social Security Number Hours **Funeral** Davs 1 □ M 2**X** F Months NY 83 212-20-0795 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a Medical Examires must be neutified at 1 ☐ Yes 2 ☐ No Director Baltimore Arbutus MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5825 Oakland Road 21227 <u>United States</u> Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 ➡No Specify Specify: White à 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AT&T Telephone Telephone Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith Rodman Anthony DeLuca 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 211 Meadowvale Road, Lutherville, Maryland 21093 Carole L. McDowell 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial 03/16/2009 Elkridge, Maryland 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service lic insee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LARGE B-CELL Umprioma luve 2008 **Physician** /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the bunal-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 🗷 No been signed by the should be detached 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy death? 1 □ Yes 2 □ No nerformed 1 ∐Yes 25. Was case referred to medical examiner? eral Director; After this certific filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No မ 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

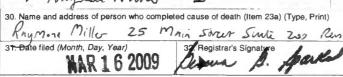
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D64395 MARCH 12,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 NCHARLES ST. 8117-209 BALTIMONE, MD 21204 DOBERMAN, MO DANIEUE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 6 2009 Registrar

	1	. Decedent's Name (First, Midd		of Mary	С	ertificat	e of		2. Date of D	Reg. No	200	9	0 8 0 9 3
hysician		James Donald M	lcGowan						Month	. 10	20	rear 09	11:23 pm
/Medical Examiner	4 -	a Fecility Name (If not institution	n, give street end	I number)				4b. City, Town, o	or Location of Dea		. County of		
- Autimitie		Frederick Vill	a Nursin	Home .	- Genes	is		Caton	sville,		Balt	imor	e
ineral rector		Social Security Number 218–26–7429	6. Sex 1 X M 2□		yrs. last birthda Yrs	Months	1 Year Days	If Under 24 H	rs. 8. Date of B	irth lay, Year) 5/19	, §	9. Birthp. Coun	ace (State or Foreigry)
	-	Isual Residence of Decedent											
T FE STOR		0a. State 10b. County		100	c. City, Town or							11	d. Inside City Limits
rector	<u> </u>		timore					rille					1 ☐ Yes 2, ¶ No
Ž	<u> </u>	De. Street and Number				10f. Zip				10g. Cit	tizen of Wh		
ā	5	13 Slate Mills	Court				212						tates
v Funeral Director	11	1. Marital Status 1 ☐ Never Married 2 ☆ Mar	ried 1 7	Decedent Ever I Forces? es 2 \(\text{\text{No}}\) Give \(X\)	in U,S. 1	3. Was Deced If Yes, spec		lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)	0-	14. Race - Black, Specify:	White, e	tc.
5	2	3 ☐ Widowed 4 ☐ Divorced	Year o	or Dates:								Whi	
Be Completed	5	15. Deceder (Specify only highe	nt's Education ast grede complete	ed)	16a. De	ve kind of wo	nk done	ation during most of w d)	vorking	16b. K	ind of Busi	ness/Ind	ustry
E		Elementary/Secondary (0-12)	Colleg	e (1-4or 5+)	Inte	. DO NOT us	se retire	1)					
To Be Comp	} -	7. Father's Name (First, Middle,	(1004)		In	suranc	e Ag				Insur		
8	3 "		Last)						lame (First, Middle		Surname)		
P		Harry McGowan							llow Sha				
		9a. Informant's Name/Relations							Rurel Route Num	-			
			verne H. McGowan (Spouse) 13 Slate Mills Court, Catonsville, Maryland 212 ethod of Disposition 20b. Place of Disposition (Spouse) Date 20c. Location - City or Town, State										
once.	120	· ·	□ Burial 2 □ Cremation 3 □ Removal from State cemetery, cremetory or other place)										
		4 Donation 5 Other (S		1	Loudon .				03/17/2	009	Balt:	imor	e, Maryla
once.	2	Signature of Funeral Service	Licensee			22. Name an 4107 V			Hubbard nue, Bal				Inc. and 21229
	2	3a. Part1. Enter the disease, or shock, or heart failure. List	complications th	at caused the	death. Do not						•		Approximate Interval Between
n		Shook, of Hoalt lairaid. List	only one cause c	or odor into.								1	Onset and Death
al	In d	nmediate Cause (Final isease or condition		<	Strok.							!	
	re	esulting in death)	a	Due	to (or as a cons	sequence of):						}	
Examiner	1												
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EX	th	iai initiateo events	C	Due t	o (or as a cons	equence of):							
cai		esulting in death) Last										į	
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ā		art II. Other significant condition	d	death but not	resulting in the	underlying ca	ause giv	en in Part I.	23b. Did	tobacco	use contri	ibute to	the cause of death
hysician/Medical		art II. Other significant condition	d	o death but not	resulting in the	underlying ca	ause giv	en in Part I.					
hysician/Medical	Pa	art II. Other significant condition	d	o death but not	resulting in the	underlying ca	ause giv	en in Part I.		tobacco Yes 2		ibute to	ably 45 Unknow
be deteched for use es the bur by Physician/Medical	Pa	art II. Other significant conditio	d	o death but not	resulting in the	underlying ca	ause giv	en in Part I.	1	Yes 2	□ No 3	Prob	
pieted by Physician/Medical	Pa	art II. Other significant conditto	d	o death but not	resulting in the	underlying ca	ause giv	en in Part I.	1	Yes 2 s an autopormed?	□ No 3	Prob	e autopsy findings lable prior to pletion of cause eath?
pieted by Physician/Medical	Pa	5. Was case referred to medica		o death but not	resulting in the	underlying ca	ause giv		24a. Was	Yes 2	□ No 3	Prob	e autopsy findings lable prior to pletion of cause
edot, page z should be deteched for use as the our Be Completed by Physician/Medical	Pa Pa	5. Was case referred to medica examiner?	Hospital				l Out	26. Place of D	24a. Was peri	s an autoromed?	□ No 3	Prob	e autopsy findings lable prior to pletion of cause eath?
To Be Completed by Physician/Medical	Pa 25	5. Was case referred to medica examiner? 1 □ Yes 2D≪0o '. Manner of Death	Hospital: 1	□ Inpatient	2 ☐ ER/Outpat 28b. Time	ient 3□ DO	o _A Oth	26. Place of D er:	24a. Was	s an autopormed? Yas 2. one) idence	□ No 3	Prob	e autopsy findings lable prior to pletion of cause eath?
actor, pege 2 should be deteched for use as the but Be Completed by Physician/Medical	Pa 25	5. Was case referred to medica examiner? 1 □ Yes 2 2 ()	Hospital: 1 28a. Da	□ Inpatient	2 ☐ ER/Outpat 28b. Time	ient 3□ DO	Oth 8c. Injur Wor	26. Place of D er:	24a. Was peri	s an autopormed? Yas 2. one) idence	□ No 3	Prob	e autopsy findings lable prior to pletion of cause eath?

State Registrar

Rayme Muli- MD

29b. Signature and title of certifier



DHMH 16 Rev 6/95

D47683

29d. Date signed (Month, Day, Year)

3/13/09

DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Month **Physician** March 10, M Kyaw Myint 23:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 473-38-4912 Yrs June 21, Director 79 Burma Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 N No Director Maryland | Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6520 Wilmett Road United States 20817 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ∐Yes 2 ⊠No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: 1 ☐ Yes 2 🖾 No Specify: Asian þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Economist World Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be S.E. Simons 2 Annette Daw Pu 19a. Informant's Name/Relationship (Type. Frint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once. Thelma Myint/Wife 6520 Wilmett Road, Bethesda, Maryland 20817 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State March 16, Montgomery Crematorium, Inc. 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Robert A. Fumiphrey Funeral Home/Bethesda-Chevy Chase, Inc. Signature of Funeral Service Licenses 7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01548 23a. Part 1. Enter the disease, or o implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 3 weeks Cerebrovascular Accident /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Pneumonia 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 🖾 No 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 No Certification: To 1 Na Inpatient 2 National ER/Outpatient 3 NoA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No Il Director: 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after 4 ☐ Homicide Hospital within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D38262 March 11, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anurita Mendhiratta, M.D. 2401 Research Blvd., Suite 336, Rockville, MD 20850 32. Registrar' Signatu State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 9:32 PM Physician Mate larch Kobert /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, May 2, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 🛛 M 2 🗆 F Days Hours 1953 55 Maryland 213-48-6391 **Director** Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location works aţ 1 Yes 2 No Director MD Baltimore Rosedale the Medical Examiner must be notified 28a-f 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ö 6735 Fordcrest Road 21237 USA items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status filed within 72 hours after 1 X Never Married 2 ☐ Married ō 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: Specify: white þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) 12 nd Mental Hygiene. marked other than clerk 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be James Gordon Matey Marjorie Jacobs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6735 Fordcrest Road Rosedale, MD Marjorie Matey/mother 21237 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service Ronald S. Wade, State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death shock, a heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trar resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: nse s 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 1 Yes 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 4 Unknown 2 No 3 Probably 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has 1 Yes 2 No certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 🗹 No 3 DOA 2 ER/Outpatient မ funeral 27. Mann r of Death 1 Natural 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) Injury 1 🗌 Yes ter death. 2 Accident filled in by the Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier (check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 29b. Signature and title of certified 0 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anth 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 19a, per Inf G889 3/20/09 TT
State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Mai	ryland / i	Certificate of		1	Reg. No.	2009	08097
	Physici /Medic		1. Decedent's Name (First, Middle, La Will	_{st)} Liam A. Phi	llips,	Sr.		2. Date of De Month Marc	Day	Year , 2009	3. Time of Death 11:20PM M
The state of the s	Examin Funeral Director		4a. Facility Name (If not institution, given Shady Grove Accessed States of	iventist Hos Sex 7. Age	spital (In yrs. last bii 62			8. Date of Bir	th ay, Year)	9. Birth	gomery place (State or Foreign ntry) ington, D.C.
Ī	Aaryland f show	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow						10d. Inside City Limits 1 ☐ Yes 2 💢 No
	with the Na or 28a-	al Director	Maryland Mont 10e. Street and Number 20663 Highla	gomery	rive	10f. Zip Code	omery Vill 20886	Lage	10g. Citiz	zen of What Cou	ntry?
036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. marked other than "ratural", or items 23a or 28a-f show marked other than "ratural", or items 23a or 28a-f show maric event, the Marie I Evaning must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 [X]Yes 2 □ No If Yes, Give Year or Dates: 10	er in U.S.	13. Was Decedent of If Yes, specify Cult	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No o Rican, etc.)		4. Race - Ameri Black, White, Specify:	can Indian,
21215-0036	filed within 72 hou Hygiene. other than "natura ent, ir Moule II	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation	16a	Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	ipation e during most of worl ed) nanic	king	16b. Kir	nd of Business/Ir	ndustry
ם	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last)		meC1	18. Mother's Nam	ne (First, Middle,	Maiden		Julive
Maryland	es 1 and 2 should be for Health and Mental fitem 27 is marked or other traumatic ever	ပ္	19a. Informant's Name/Relationship (o. Mailing Address (Stree	•	ral Route Numb	er. Citv or	ia Broo	p Code)
ď	Pages 1 and nent of Heal ant: If item 2 ant: or other and		Margaret Philli 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specia	Removal from State	20b. Place o cemete Gate Of H	Monts f Disposition (Name of ry, crematory or other place) eaven Cemet	i i	Date	20c. Lo	cation - City or T	86 own, State ng, Maryland
Balti	permit. Pages Department of Important: If its any injury or o		21. Signature of Fundral Service Lice	Test 1	M00335	22. Name and Addi Rockvill Rockvil	ess of Facility Rolle, Inc. Le, Maryla	pert A. 300 West and 2085	Pump Mon 0-28	hrey Furtgomery	neral Home/ Avenue
	Physician /Medical		23a. Part 1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the one cause on each line a. Cardio e. Due to (or as a	nic Sho	ock	ing, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death Days
	ansit aust	Examiner	Sequentially list conditions, if any leading to instructions cause. Enter Underlying Cause (Disease or Injury that initiated events	b. Severe Cardiomyopathy Coeto (cras a consequence of) c. Coronary Artery Disease							Months Years
68/60,	rificate be executed ng physician and as the burial-transit	ledical Exa	resulting in death) Last	Due to (or as a	consequence	of):					Years
POX	death cer e attendir d for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t 9 Unknown	☐ Fetal death	n 3 ☐ Ectopic pregnar 5 ☐ Other (specify)			2	3d. Date of deliv	rery Day Year
л, Г	requires that the leen signed by th hould be detache	þ	Part II. Other significant conditions	contributing to death but ary Artery	_		iven in Part I.				the cause of death?
ပ္က	is ≌ ⊲	Completed		Renal Fai		Graft		24a. Was	an osy rmed?	24b. Were aut	opsy findings available ompletion of cause of
VItal	s certific irector,	Be	25. Was case referred to medical examiner?	Hospital: 1 🕅 Innation	+ 2 T EB/O	strationt 3 DOA Of	26. Place of Dea	th (Check only o	ne)		
DIVISION OF	To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page:	1 Industrial 2 EA/Outpatient 3 DOA 4 Nursing Home 5 Hesidence 6 Outlet									ny)
Ž O	pital or Att burs after d eral Direct filled in by f		27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28b. Time of Injury M M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred								
	the Hos iin 24 ho the Fun thetely	Medical	(Check only 2 Medical Example one)	miner: On the basis of and manner state	examination at	nd/or investigation, in my	opinion, death occu	rred at the time,	date and	place, and due	to the cause(s)
	with Con	Σ	29b. Signature and title of certifier	Mhy	LI M	Da	156 number		MAR	e signed (Month)	,
	Sta		30. Name and address of person who	completed cause of dea	ath (Item 23a)	(Type, Print) 9901 Med Rockvill	ical Cento e, Maryla	er Drive nd 20850	3		

State Registrar

MAR 1 6 2009 DHMH 17 Rev 1/2001

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 08098 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month 1 **Physician** 5.20 a M BENIUN Marc /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** COMMUNITY HOSPITAL LANHAM PRINCE GEORGE'S 8. Date of Birth (Month, Day, Year) 08/29/1940 7. Age (In yrs_last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Min. Months Days Hours WASHINGTON DC 212-38-2983 68 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 X No Funeral Director PRINCE GEORGE'S MD COLLEGE PARK 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be illed within 72 hours after death with ment of Health and Mental Hyglene. ant: if item 27 is marked other than "natural", or items 23a or ury or other traumatic event, Ira Marier Examine must be. 5006 PADUCAH ROAD 20740 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify ģ Specify: WHITE 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) US ARMY CORP OF College (1-4or 5+) Elementary/Secondary (0-12) ENGINEERS INSPECTOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be SAMUEL **PARKS** LILLIAN HAMENT ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai once. SUZANNE PARKS / WIFE 5006 PADUCAH ROAD, COLLEGE PARK, MD 20b. Place of Disposition (Name of BETHETACOBOTANSHE Place) VESHEAR 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/13/2009 ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MUTERL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed physiclan and s the burial-transi Exami Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No 3 Probably 4 Unknown Completed EVIOUS CAYLDIAE ARREST 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy 1 ☐ Yes 2 **X** No 1 Tes 2 🗆 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ FR/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 GOOD LUCK ROAD, LANHAM, MD 20706 STEU 31. Date filed (Month, Day, Year) State Registrar

			for State Registrar	State	of Ma	aryland / Depa <i>Ce</i>	artment of <i>rtificate o</i>				giene Reg. No. 2 ()	09	08099
	Dhusis		1. Decedent's Name (First, Mic	fdle, Last)						2. Date of De	ath		3. Time of Death
	Physici /Medi			Mildre	ed La	arson Raff				Month Marcl	Day 1 11, 20	Year 109	8:30PM M
-	Examir	er	4a. Facility Name (If not institut	ion, give street and	number)		4b. City, Town	, or Location	on of Death		4c. County	of Death	
			Montgomery V				Mont	gomer	y Vil				gomery
	Funeral Director		5. Social Security Number	6. Sex 1 □ M 2 🛣 F	7. Age	(In yrs. last birthday) Yrs.	If Under 1 Year Months Day			(Month, Da	th y, Year)	Cou	
			219-54-7398 Usual Residence of Decedent			82 Yrs.				August	8, 1926	Noi	rth Dakota
	how	_	10a. State 10b. Coun	ty		10c. City, Town or Lo	cation					1	Od. Inside City Limits
	e Ma Ba-f s	Director	Maryland M	ontgomery]	Rockv	ille				1∭XYes 2☐No
	ith th	Dir	10e. Street and Number			-	10f. Zip Code)			10g. Citizen of	What Cour	ntry?
	s 23a	eral		Grandin A			1	208				ited	States
	item	Funeral	11. Marital Status 1 □ Never Married 2 □ Ma	Armed	ecedent E Forces? s 2 X N	Ever in U.S. 13.	Was Decedent o If Yes, specify Cu	f Hispanic Jban, Mexic	Origin? (Sp can, Puerto	ecify Yes or No Rican, etc.)	14. Rad Blad	e - Americ ck, White,	can Indian, etc.
036	72 hours after death with the Maryland natural", or items 23a or 28a-f show iteal Everyland Lust be reaffied at	by	3 X Widowed 4 □ Divorce	If Yes	Give		1∐Yes 2⊠N	o <i>Sp</i> ec	ify:		Specify		T
2-0	72 hours "natural", dien Ere	Completed by	15. Decede	ent's Education	-d\	16a. Dece	dent's Usual Occ	upation			16b. Kind of Bi		Mite dustry
21	tthin 7 ne.	nple	Elementary/Secondary (0-12)	nest grade complete College	(1-4or 5-	life	kind of work don DO NOT use reti	e during m red)	iost of work	ing	Montg	omerv	County
21	led wi tygier her th	Co	12				Off	ical			Board	of E	Elections
and	be fill	Be	17. Father's Name (First, Middle	•				18. Mo	ther's Name	e (First, Middle,	Maiden Surnan	ne)	
Ž	hould d Me mark matic	မ	19a. Informant's Name/Relation	Oscar La	ırson			<u> </u>			ma Sjon		
Ma	id 2 s Ith an 27 is :						ng Address (Stre						
ē,	f Hea f Hea item other		David W. Raf			20b. Place of Dispo	00 River	Road	Г	Date	ryland . 20c. Location -		
E O	Pages ent o nt; If i		1 ☐ Burial 2 🕅 Cremation 4 ☐ Donation 5 ☐ Other (n 3 Removal from	m State	Montgome Crematori	natory or other p	lace)	Marcl 2009	n 16,			,
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturary injury or other traumatic event, the Medical once.		21. Signature of Funeral Service		100	22	. Name and Add	ress of Fac			Pumphre	v Fun	laryland eral Home/
<u> </u>	8 2 2 8 8	1	Ley) Kealer	/ M	00335	Rockvil Rockvil	le, I le, M	nc. 3 arvla	00 West nd 2085	Montgoi 0-2805	nery	eral Home/ Avenue
			23a. Part1. Enter the disease, shock, or heart failure. Lis	or complications tha st only one cause or	t caused each line	the death. Do not ent	er the mode of d	ying, such	as cardiac	or respiratory ar	rest,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Lur	g Ca	ncer							Onset and Death
	/Medical Examiner		resulting in death)			consequence of):							
44		ē	Sequentially list conditions, if any, leading to immediate			Effusion consequence of):							
bl	d d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<	-	nsion							
0,	an an rial-tr		resulting in death) Last			consequence of):							
68760,	ificate be executed physician and as the burial-transit	edical		d. Hyp	othy	roism							
9 X			IF FEMALE:	23c. If yes, c	utcome	of pregnancy							
Вох	atter for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Liv	e birth 2	2 ☐ Fetal death 3 ☐	Ectopic pregnar Other (specify)				23d. Dat Mo	e of delive nth	ery Day Year
P.O.	The law requires that the death cert ate has been signed by the attending bage 2 should be detached for use a	Physician/M	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	9 🗆 Un									
S, F	res thai signed I be det	by P	Part II. Other significant condit	tions contributing to	death but	t not resulting in the ur	derlying cause g	iven in Par	t I.	23e. Did to	bacco use contr	ibute to th	e cause of death?
of Vital Records,	w require			Pn	eumo	nia				1 □ Y	es 2□No	3 ☐ Prob	ably 4 🔀 Unknown
ecc	e law r	Completed		Aorti	c An	eurysm				24a. Was a		Vere autor	osy findings available
<u>=</u>	: The	Con								autops perfor	med? d	leath?	npletion of cause of
Vita	iclan: The certificate ector, pag	Be	25. Was case referred to medica examiner?						ce of Death	(Check only on			
of	hys this	<u>유</u>	1 ☐ Yes 2 🕅 No 27. Manner of Death			t 2 ER/Outpatien 28b. Time of	I 3 LI DOA	her: 4 🔀 i	Nursing Hor	ne 5 🗆 Reside	ence 6 Othe	er (Specify)
	ding I	ti.	1 X Natural 5 ☐ Pendi		e of Injury onth, Day,	Year) 200. Time of Injury	28c. Inju Wo M 1 F	ury at ork? ∃Yes 2[Į.	28d. Describe h	ow injury occurre	ed	
Division	Attending Physiclan: It death. ector: After this certifice by the funeral director, p	iica I	3 ☐ Suicide 6 ☐ Could	I not be 28e. Plac	e of Injur	y - At home, farm, stre				28f. Location (S	treet and Numbe	er or Bural	I Route Number
<u>–</u>	tal or Att s after d al Direct ed in by t	Certification:	4 ☐ Homicide determ	buil	ding, etc.	(Specify)			60	City or Towi	n, State)		riodio riambol,
Ω,			(Check only 2 Medica	ing Physician: To the	ne best of	my knowledge, death	occurred at the	time, date	and place, a	and due to the c	ause(s) and ma	nner as st	ated,
1.	To the within 2 To the I complet	Medical	one) 29b. Signature and title of cartific	and ma	nner state	ed.		se number					
	Sor With			- On		118.1	1 .			2	9d. Date signed	Wonth, L	Jay, Year)
		-	30. Name and address of persor	who completed car	use of de	ath (Item 23a) (Tuno F		0579	374		7 (13	107	
			Ahmed Heshmat				•	ckvi	lle. N	Maryland	1 20855		
	Stat	_	31. Date filed (Month, Day, Year	32.	Registrar	's Signature							
	Registra	r	MAR 162	UUY Dens	an	A. par							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ROBERTS TOSEPH 28 200 02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Alice Manor Nursing Home Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Nov 13, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Min. Hours 1 M 2 □ F 71 1937 Maryland Director 218-36-4425 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at MD Baltimore 1 X Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2095 Rockrose Avenue 21215 USA Funeral 12. Was Decedent Ever in U.Sunk Armed Forces?

1 ☐ Yes, 2 ☐ No If Yes, Give Year or Dates:

1 ☐ Yes 2 ☒ No Specify:

1 ☐ Yes 2 ☒ No Specify: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 'natural", or Baltimore, Maryland 21215-0036 Specify: black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry unk Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the unk unk al Hygie unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be filment of Health and Mental Hant: If item 27 is marked oth traumatic ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 2095 Rockrose Avenue Baltimore, MD Alice Manor Nursing Home 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4□Donation 5\Other(Specify) in state 21. Signatur of Funeral S. rule Licensee State Anatomy Board 655 W. Baltimore Street rector. m Baltimore, MD 21201 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical as a consequence Examiner Caquentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner a consequence of) requires that the death certificate be executed use as the burial-trai Due to (or as a consequence of) aftending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a P.0. 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No The law 24a. Was an page 2 autopsy certificate 2 Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 | Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred Mannel eath 28c. Injury at Work? Injury (Month, Day Year) atural 5 Pending M investigation 1 ☐ Yes 2 ☐ No Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined. 4 ☐ Homicide

after death.

I Director: After this of in by the funeral d or Attending within 24 hours aft

To the Funeral Di

completely filled in To the Hospital

> State Registrar

Wedical

29b. Signature and title of certifier

29a. Certifier

Entow

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Marion L. Spencer State of Maryland / Department of Health and Mental Hygiene 2009 08101 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day March 13, 2009 Medical Examiner 2010 hrs Marion Spencer 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death c. County of Death Perring Parkway & Hillsway Avenue Parkville **Baltimore County** 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Director Months Days Hours Min 11-20-1942 N.C. 216-42-8645 $_2X_F$ М 66 Usual Residence of Decedent iny 10a. State 10b. County Oc. City, Town or Location 10d. Inside City Limits 1 X Yes 2 28a-f show N/A Balto MD death with the Maryland Director 10e. Street and Number 10a. Citizen of What Country? 10f. Zip Code USA 129 Solar Circle 21234 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 Married White, etc. Yes 2 X No after Widowed Divorced f Yes Give Year Yes 2 X No specify Black 4 X Specify "natural", 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) ges I and 2 should be filed within 72 h
of Health and Mental Hygiene.
If item 27 is marked other than "... Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Private Homes N/A Domestic 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irene Carter George Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4328 Shamrock Avenue Balto, MD 21206 Michelle Windley-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation Trinity Cemetery 3-20-09 Balto, MD Department of Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 21202 1101 E. North Avenue Balto, MD Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each tine en Onset and /Medical a. Multiple Injuries Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury trial initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician for use as the burial Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Ectopic pregnancy Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify, Yes 2 No 9 V Unknown detached for Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ <u>ت</u> Yes 2 ✔ No 3 Probably 4 Completed Records, has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? certificate ✓ Yes 2 No 1 🗸 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Inpatient 2 Other: DOA this ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene 1 V Yes No After t 28a. Date of Injury (Month, Day Year) Mar 13, 2009 27. Manner of Death 28b. Time of Injury 28c. Injury at Work's 28d. Describe how injury occurred Certification: Pedestrian struck by auto 1 n 24 hours after death.

e Funeral Director: A letely filled in by the fu Natural 2009 hrs Pending Yes 2 V No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State)
Perring Parkway & Hillsway Avenue, Parkville, MD determined (Specify) Local Street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** To the 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 14, 2009 30. Name and address of person who completed cause of death (Item 23a)

State Registrar Ana Rubio MD.

31. Date filed (Month, Day, Year

82. Registrar's Signature

Assistant Medical Examiner

ORIGINAL

111 Penn Street, Baltimore, MD 21201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 3 **Physician** SIMMONS JUNE 8:40 AM LAVERNE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number, Examiner Frederick Villa Nursing Home Catonsville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 6/19/1932 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Deys Hours Months 1 □ M 2 🛛 F 76 Director 218-28-3110 Maryland Usual Residence of Decedent permit. Pegas 1 end 2 should be filed within 72 hours aftar death with the Maryland Depertment of Health end Mentel Hygiene.
Important: if fem 27 is marked other than "natural", or harm any injury or other trainment. 10c. City, Town or Location 10d. Inside City Limits 10a Stete 10b County 1 ☐ Yes 2 X No MD Baltimore Halethorpe Funeral Director 10g. Citizen of What Country? 10e. Street end Number 10f. Zin Code 1923 Brady Avenue 21227 **USA** 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specity: White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Merriel H. Curtin Minnie Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Darcy L. Simmons / Spouse 1923 Brady Avenue, Halethorpe, Maryland 21227 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Bayview Crematory 3/16/09 Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Physiclan/Medical Examiner or Attanding Physician: The law requiras that the death certificata ba axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last After this certificate has been signed by the attending physician and funeral director, pege 2 should be datached for use es tha bunal-trar Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown fon's þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 | Yes 2 | ₩6 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Injury 1 (Natural 5 Pending 1 Yes 2 No within 24 hours after deeth.

To the Funeral Director: A
completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital within 24 hours a To the Funeral D 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29d. Date signed (Month, Day, Year) 29b. Signature and tiple of certifier 2009 6095 Marshalle Dr. 30. Name end eddress of persor 31. Date filed (Month, Day, State Registrar

DHMH 16 Rev 6/95

			State of Maryland / Department of		ental Hygie	ne 2009	00103
			State Registrar Certificate of 1. Decedent's Name (First, Middle, Last)		Reg. 2. Date of Death	No. UUJ	00103
	Physici		MARY Shaw	'	Month	Day Year	3. Time of Death
and a	/Medio Examir			or Location of Death	the at	9 2009 4c. County of Death	12:57
			ILMMC Balt	more		n/a	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birthp	lace (State or Foreign try)
	Director		216-34-0170 The Park Triangle		2/17/1938	B Penns	sylvania
	yland		10a. State 10b. County 10c. City, Town or Location			10	Od. Inside City Limits
	e Mar Ba-f s	Director	MD n/a Baltimore				1XYes 2□No
	/ith th	Dire	10e. Street and Number 10f. Zip Code			Citizen of What Coun	try?
	eath v	Funeral	601 South Charles Street 21201	Uia-rai- Odai-0 (O-ra		SA	
က	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Medical Examinational by motified at	Fun	Armed Forces? If Yes, specify Cub 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No □ □	Hispanic Origin? (Spec can, Mexican, Puerto R	lican, etc.)	14. Race - America Black, White, e	
21215-0036	ral", o	d by	3 XWidowed 4 □ Divorced If Yes, Give Year or Dates:	Specify:		Specify: Wh	ite
15-("natu	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occu (Give kind of work done	during most of working	16b	. Kind of Business/Ind	lustry
12	filed withir Hygiene. other than	dmc	Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker	id)		Orm Home	
d 2	be filed valued Hygic dother event, It	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (Own Home den Surname)	
/lar	O # D O	To B	Merle C. Kroushour	Winifred	J. Danne	r	
lar)	2 should and Mer is marke raumatic		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Stree				
6, 	s 1 and 2 should of Health and Mer item 27 is marke other traumatic		Farrell R. Shaw, Jr. / Son 3392 Dulany S				
_			20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State			Location - City or Tov	
Ħ	# 분 변 등 .		4 □ Donation 5 □ Other (Specify) Md. Veterans Cemeral Service Licensee 22. Signatur, of Funeral Service Licensee 22. Name and Address	tery: 3/16/ ess of Facility Hub			
m	Depa Impo any i	0 (ens Avenue,			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line.				Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition				Onset and Death
-	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
		-e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	cuted ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter undulying Cause (Disease or injury that initiated events c.				
0	cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consequence of):				
		dical	d				
9 X	eath certific attending p for use as	/Me	IF FEMALE: 23b Was deceded progress 23c. If yes, outcome of pregnancy		_		
Вох	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Med	in the past 12 months?	су		23d. Date of deliver Month	ry Day Year
P.O.	that the died by the detached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 5 ☐ Other (specify) ☐				
S,	w requires that s been signed t should be deta	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I.	23e. Did tobacc	o use contribute to the	e cause of death?
ord	een s	ted			1 ☐ Yes	2 No 3 Proba	ably 4 Unknown
ဒ္ဌင	e law has b e 2 st	Completed			24a. Was an autopsy	prior to com	sy findings available inpletion of cause of
a	n: Th ficate r, pag				performed; 1 □ Yes 2 2		2.∕ANo
₹ :	/sicla s certi lirecto	Be C	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Mnpatient 2 ER/Outpatient 3 DOA Oth	26. Place of Death (
ָם ני י	ig Phy ter thi	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury		d. Describe how in	6 ☐ Other (Specify, jury occurred)
Sio.	endin sath. or: Af he fur	atio	2 Accident investigation M 1	Yes 2 No			
Division of Vital Records,	or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28	f. Location (Street City or Town, Sta	and Number or Rural	Route Number,
	ours a eral C		29a. Certifier 17 Certifying Physician: To the best of my knowledge, death occurred at the ti	ima data and place as	al due to the course	/a\ and	()
	of the floogital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my one) and manner stated.	opinion, death occurred	at the time, date a	and place, and due to	the cause(s)
i i	vithir To th	Me	29b. Signature and fille of certifier 29c. Licens	se number	29d. [Date signed (Month, D	ay, Year)
			1 /year Chil MD P3	12054	-	3/9/21	209
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ryan Arnold 27. S. Corre				
	Stat	6	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1 St Ba	Limere	m) Z	1021
	Registra		MAR 1 6 2009 Canage S. Jakes				
			, 1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Jane Lee Sanders 5:10 A M March 16, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner Catonsville Commons Catonsville Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2X F Months 87 215-16-5250 **Director** May 2, 1921 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "welcal Eventing or use the retified at Director 1 □Yes 2 □XNo MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 916 Francis Avenue 21227 Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or iter 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: ģ Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stanley L. Roth Valetta M. Galloway 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 is
any Injury or other trau Sandra Lee Godman - Daughter 916 Francis Avenue, Arbutus, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 3-19-2009 4 □ Conation 5 □ Other (Specify) Baltimore, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown signed by 1 I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica stely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be To the Hospital or Atte within 24 hours after dea To the Funeral Directo completely filled in by the 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) MAR 1 6 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1009

and manner stated

29d. Date signed (Month, Day, Year)

36942, marea 16,

redrick RD. Cotanguille, MO 2/228

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MAZEH 3 **Physician** Lola D. Savina 5.502 2004 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BATTIMORE DONSHINGTON MEDICAL Chani BURNIE AMME ARUN DEL CENTER 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Year) 1 □ M 💥 🗆 F Months Days Hours 216-14-8706 86 10/11/1922 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State Director 1 ☐ Yes 2 ☑ No MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 250 Kentucky Avenue 21122 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White à 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oliver Wagner Lola Hood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3126 Bel Air Drive Bowie, MD 20715
Date Double Doub Michael Savina - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Meadow Ridge Mem. Pk 03/18/09 5 ☐ Other (Specify) Elkridge, MD 4 Donation 21. Signature of Funeral Se 22. Name and Address of Facilit Harry H. Witzke's Family F.H. Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 wil M01411 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MEUMONIA disease or condition resulting in death) (or as a consequence of): ARKINSON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence off-Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 death? 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient ဥ 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

P.0. Division of Vital Records, **Funeral**

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.

Physician

/Medical

Examiner

attending physician a for use as the burial-

ģ signed by

icate has been się , page 2 should b

Baltimore,

certificate To the Hospital or Attending Physician: this certific al director, After thi funeral within 24 hours after death.

To the Funeral Director; A completely filled in by the fu

> State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day,



29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 24a per verb., 8889,03/19/09dhb
State of Maryland / Department of Health and Mental Hygiene
1- State Amend Item 20b per fh, 8889,03/13/09dhb
Certificate of Death

Reg. No. 200 Reg. No. 20 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 6:20 AM Bernice /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Manor Care atonsville Baltimore f Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) A 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 93 Yrs. Months Days Hours Min. 1□ M 2 F Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ortant: If item 27 is marked other than "natura", or items 23a or 28a-f sho injury or other traumatic event, ibs Modical Examinar must be notified at 1 ☐ Yes 2 No Kaltimore Director tima MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2120 3408 eston USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Tes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify Black Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last) College (1-4or 5+) Private omestic permit, Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important; If Item 27 Is marked other the any injury or other trainment 18. Mother's Name (First, Middle, Maiden Surname) Be 1 urray walker ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Z1207 3408 Keston Rd. ann on day 20c. Location - City or Town, State Place of Disposition (Name of White Hard)

Report Tamatory Celling Hack y

22. Name and Address of Pacility 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State -6-09 Raltinore, MD 4 ☐ Donation 5 ☐ Other (Specify) Vaughn C. Greene funeral Sis 21. Signature of Funeral Service Licenses 8728 Liberty Rd. Kandalls-four, MOZIRI 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as card ic or respiratory arrest, shock, or heart sibre. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OF Physician A FEMUR COMPLICATIONS LEFT FRACTU disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IMD Examiner Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER sate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CARDIOVASCULAR 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 □ No After this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ★Yes 2 □ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred WALIGNG 5 ☐ Pending investigation 1 Natural WHILE TRIPPED 01-24-2009 6:30 PM 1 ☐ Yes 2 XNo 2 Accident in HER HOME 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2020 FEATHERSED IN 3 Suicide determined 4 Homicide 120mE 514, WOUDLAWN MD 11207 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 03-02-2009 D0059107 W.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 210 BUSINESS MD UMA CENTER DRIVE REISTERSTOWN 31. Date filed (Month, Day, Year) State MAR 13 2009 Registrar

1 Br

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Jacob Stephen Sutton 2009 /Medical 4c. County of Deat 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Unk **Funeral** Months 0*2*^M232009 Maryland **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Waldorf 1 ☐ Yes 2 No Charles Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code U.S.A. 20602 12102 Brackenridge Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 X Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 XNo 2 Yes. Give Specify 3 Widowed 4 Divorced Year or Dates Completed 16a. Tecedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Infant 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than Infant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill Health and Mental H tem 27 is marked oth Be Janet M. Rootes Richard C. Sutton, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Richard C. Sutton, Jr. - Father 12102 Brackenridge Court Waldorf, MD 20602 permit. Pages 1 an.
Department of Healt
Important: If Item 27
any injury or other tra Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other to Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Memorial 03/10/09 Timonium, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility 5305 Harford Road 21. Signature of Funeral Service Licensee Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Exami g physician and as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Box 68760. Physician/Medical IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav for Pregnant at time of death 5 Other (specify) signed by the att 9 Unknown Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð should be 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 □ No (es 2 No 1 Yes certificate 25. Was case referred to medical 26. Place of Death (Check only one) director Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 🗷 No Inpatient 2 ER/Outpatient 3 DOA မ funeral 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide

or Attending Physician: The law requires that the death certificate be executed after death. filled in by the Hospital

24 hours Funeral within 24 hou

To the Funer

completely file the

State Registrar 29a. Certifier

one)

(check only

29b. Signature and title of

Medical

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

erson who completed cause of

and manner stated.

600 North Wolfe St, Baltimore, MD, 21287

31. Date filed (Month, Day, Year) MAR 16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 20<u>09</u> Month March 12, Sears 1:40

4b, City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min.

Essex

Days

7. Age (In yrs. last birthday)

90

Physician /Medical Examiner 1 - For State Registrar

5. Social Security Number

215-03-9238

4a. Facility Name (If not institution, give street and number)

Riverview Nursing Home

Funeral Director

28a-f shov ö items 23a ō "natural".

Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County event, the Medical Examiner must be notified at Dundalk Director Maryland Baltimore 10f. Zip Code 10e. Street and Number 21222 8109 Bletzer Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. Was Deceue... _ Armed Forces? ¹ □Yes 2 🛣No 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) 72 (Specify only highest grade completed) 12 should be filed within 7 th and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 8 years Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret O'Toole Harry Clark ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If item 27 Is r any Injury or other traur James Sears son 8109 Bletzer Road, Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March^{ate} 16. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cardens of Faith Cemetery 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Connelly Funeral Home of Dundalk, P.A. Attorn 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure distance on each line. Immediate Cause (Final anan/o **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to for as a pensuouence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 | Ectopic pregnancy in the past 12 mopths? Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No P.O. 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed 24a. Was an has autopsy 1 ☐Yes 2 ☑No 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number D-38754 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASTERN BLVD. M.D-2/22/1

 P^{M} 4c. County of Death Baltimore 8. Date of Birth (Month, Day, July 15, 9. Birthplace (State or Foreign 1918 Maryland 10d. Inside City Limits 1 ☐ Yes 2 No 10g, Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Own Home 20c. Location - City or Town, State Rosedale, Maryland Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (*Month*, *Day*, *Year*)
03-13-2009

State Registrar 31. Date filed (Month, Day, Year)

MAR 1 6 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #30 per DVR 9889 3/16/09 TT
State of Maryland / Department of Health and Mental Hygiene 1- State RegistrarAmend 29c per DVR g889 3/16/ Pertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Yea **Physician** Marc 2005 Mildred Shelton /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (If not institution, give street and number) **Examiner** allimore Sinai Hospita 5. Social Security Number ltimore しな If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours Months 227-20-7556 1 □ M 2 🖾 F 87 Midred Director 7-21-1921 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10h County 10c. City, Town or Location 10a. State show ed other than "natural", or items 23a or 28a-f show event, the Medical Experiment is ust be notified at 1X Yes 2 ☐ No Director Ral timpre M) n/a 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 301 Malinan Street # 908 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give' Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. Specify: African American 1 ☐ Never Married 2 ☐ Married Known 1 ☐Yes 2 ☑No Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore, Maryland 2121 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed withii Health and Mental Hygiene. Housewife Danestic 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Ora Shelton Jones Austin Shelton ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is 4162 Maple Path Circle, Nottingham, MD 21236 Ebnest Stokes/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 6 1 □ Burial 2 □ Cremation 3 □ Removal from State injury (4 Donation 5 □Other (Specify) Family Plot 3-19-09 Kenbridge, VA 22. Name and Address of Facility Wile Fineral Home P.A. of Balto. Co. 21. Signature of Funeral Service Licensee any ir andar 9200 LibertyRoad, Randallstown, MD 21133 23a. lart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Soliator disease or condition resulting in death) /Medical Due to (or as a consequence): Examiner Quadripleara Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque ce of): Examiner executed physician and the burial-tran Due to (or as a consequence of) Box 68760, certificate be Physician/Medical attending I for use as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) □Yes 2□No P.0. ed by the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 performed this certificate 1 ☐ Yes 2 ☑ No **Division of Vital** 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 des 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ۵ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: Hospital or Attending 1 ☐ Natural 2 ☐ Accident Injury 5 Pending investigation 2300 07/2009 1 □ Yes 2 No Fall-unwithessed death within 24 hours after death To the Funeral Director: filled in by the 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Mayror nursing 4204 old Milford Miltord Center 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier bt852 M 200 Bu 03/13/03 D67672 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jamshed Ahmad Zuberi, MD SInai Hospital 2435 W. Belvedere Ave Baltimore, MD 21215 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 6 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month March 1. Decedent's Name (First, Middle, Last) 13. 2009 Year 8:30am Schmiedt Rudo1f 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospice Dove House Westminster

Physician

/Medical

Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be exec Division of Vital Records, P.O. Box 68760,

Funeral		5. Social Security N	umber	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Bird (Month, Da May 5,	th y, Year)	Co	hplace (State or Foreign untry)			
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8	ŀ	Usual Residence of 10a. State	10b. County		10c Cit	y, Town or Lo	cation			 		T	10d. Inside City Limits			
Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventing 1 and other traumatic event, the Medical Eventing 1 and once.	Director	MD	Car	coll		Ldersbu							1 □Yes X□No			
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items	Funeral	 Marital Status Never Marri 	OT Man	Armed I	cedent Ever in U. Forces? s 2 X No	S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Orig in, Mexican,	n? (Spe , Puerto F	Rican, etc.)	- 14. Ha	ace - Ame ack, White	rican Indian, , etc.			
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Ith an		Mrs. Boz			Spouse)	1	Oak Hill									
f Hea		20a. Method of Disp			20b F	Place of Dispo	sition (Name of	1		ate	20c. Location					
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Departr Imports any Inju		21. Signature of Fu	ineral Service	Licensee	idt 1	2	HAIGHT FU PO Box 19	SS OF Facility NERAL 5 Sylve	HOMI	E & CHA	PEL, P.	.А.				
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within 24 hours after death. To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should	Medical Co	29a. Certifier (Check only one)		Examiner: On the			th occurred at the ti nvestigation, in my o									
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	/Medic	al	Dorothy Jane	Scrive			4h City T	Our Or	Location	of Dooth	March		2009 c. County of Death	1:25 A M		
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			12217 Scarle 5. Social Security Number	6. Sex	7. Age (In yrs. I	last hirthday)	If Under		If Under	24 Hrs.	8. Date of Bi	irth	9. Birth	place (State or Foreign		
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ary	shour Ind M	-	19a. Informant's Name/Relations	ship (Type. Print)		19b. Mailin	ng Address	(Street a	and Numb	er or Ru	ral Route Num	ber, City	or Town, State, Zomac, Maj	ip Code)		
Ξ	alth a		Katherine Scriv	e Dufresn	e/ _{Daughte}	12217	Scar.	ret	rana	ger	DIIVe,	TUC	omac, mai	20854		
ē,	ges 1 and 2 should be filed within 72 hours after death with the Maryla nt of Health and Mental Hyglene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Markeal Experience, ust be rectified at		20a. Method of Disposition		20h P	Place of Dispo	sition (Nam	e of her place	e)	1	Date		Location - City or T			
E	Page nent on		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		State Nor Men	emetery crei th My norial	rtle E Garde	each	n Ma	arch	14, 2009	So	orth Hyrt outh Caro	le Beach, lina		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau once.		21. Signature of Funeral Service	Licensee						ty	Funeral					
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			23a. Part 1. Enter the disease, o shock, or heart failure. Lis	r complications that of	caused the death									Approximate Interval Between		
200	Physician		Immediate Cause (Final disease or condition		ahepati	c bile	duct	can	cer					Onset and Death		
	/Medical		resulting in death)	ч.	(or as a consequ											
	Examiner		Commentation line and distance	h												
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a consequ	uence of):										
*	nd trans	Examiner	that initiated events	с												
Ő,	e exe ian a urial-	Ě	resulting in death) Last	Due to	(or as a consequ	uence of):										
8760,	icate be executed physician and the burial-transit	dical		d												
9	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Mec	IF FEMALE:	00- 1/												
Вох	ath c	Physician/Me	23b. Was decedent pregnant in the past 12_months?	1 Live	tcome of pregna birth 2 Feta	death 3	Ectopic pr		/				23d. Date of deli Month	very Day Year		
0	at the de by the a tached f	/sic	1 □Yes 2 🛂 No 9 □ Unknown	4 □ Preg 9 □ Unki	nant at time of d nown	ieath 5t	Other (spe	ecity)								
σ.	that the		Part II. Other significant condit	ions contributing to d	eath but not resu	ulting in the u	ınderlyina ca	use give	en in Part I	 I.	23e. Did	l tobacco	use contribute to	the cause of death?		
of Vital Records,	signed be det	d by	Vascular deme	ntia, hype	ertensio	n esse	ential				1 🗆]Yes	2 ⊠ No 3 □ Pro	obably 4 🗌 Unknown		
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a	ician: The certificate ector, pag										1 □ Yes	2 🔯 N		2□No		
<u>Ş</u>	siciar certii recto	Be	25. Was case referred to medica examiner?	Hospital		ED/0		Othe	25.		th (Check only					
of	iding Physician: th. : After this certifica s funeral director, p	L.	1 Yes 2 XNo 27. Manner of Death	28a. Date		ER/Outpatie		A Bc. Injury	4 LI N	ursing Ho	ome 5 ⊠ Res 28d. Describe		6 ☐ Other (Spec	cify)		
on	ding h. After fune	Ë	1 X Natural 5 ☐ Pendi		nth, Day, Year)	Injury	M	Work	? Yes 2□	INo	204. 5 0001.50		ary securiou			
S	I or Attendi after death. Director: A I in by the fu	fica	3 Suicide 6 Could	not he	of Injury - At ho	l ome, farm, sti	reet, factory,				28f. Location	(Street	and Number or Ru	ral Route Number,		
Division	lor A after Dire	Certification: To	4 ☐ Homicide determ	build	e of Injury - At ho ing, etc. <i>(Specif</i>	(y)					City or To	own, Sta	ite)			
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 🔀 Certifyi	ing Physician: To the	e best of my kno	wledge, deal	th occurred	at the tin	ne, date a	nd place	, and due to th	ne cause	(s) and manner as	stated.		
1	e Ho e Fu letely	Medical	(Check only 2 Medica one)	I Examiner: On the I and mar	pasis of examina nner stated.	ation and/or in	nvestigation,	in my o	pinion, de	ath occur	rred at the time	e, date a	ind place, and due	to the cause(s)		
1	To th Withir To th COMP	M	29b. Signature and title of certific	er U	_	0	29c	License	e number			29d. C	Date signed (Month	n, Day, Year)		
			Jan	me D		5	VA(1010	03871	4			319/1	0 7		
				who completed cau			Print)									
_			Joanne G. Crant	z, M.D. 8	316 Arl:	ington	B1vd	#31	0, Fa	airfa	ax, Vir	gini	ia 22031	•		
	Sta		31. Date filed (Month, Day, Year	32.1	Registrar's Signa	ture	4									
	Registr	ar	MAR 1 6 2	UUY Dene	a p.	1900	-									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hos spital Salti um UF If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months Days Hours Min. | Month, Day 5. Social Security Number 7. Age (In yrs. last birthday)
Yrs. **Funeral** 9 Birthplace (State or Foreign 216-34-9812 Usual Residence of Decedent 1 M 2 □ F Months Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 1 Yes 2 No Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or ", or items 23a caminer must be Funeral Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status D partment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item amy injury or other traumatic event, the Medical Examiner once. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Black Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) stodian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pencer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rufal Route Number, City or Town, State, Zip Code) (Sister) Blac Ave. Md. 21 Ston Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
JOSEPH RUSS Funeral H
2222 W. North Ave. Balto 21. Signature of Funeral Service Licensee 23a. Part | Enter the dilease, or complications that bused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner mulh - cry and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? Yes 22 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ≱Inpatient ို 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending nin 24 hours after death. 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours of To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mhunda D 28855 2009 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jinai Hospital

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Registrar

31. Date filed (Month, Day, Year)

MAR 1 6 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date . Month 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 3:40 PM Robert Lee Simpkins Jr 2009 . Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death omic 24 Hrs. 8. Date of Birth (Month, Day, Sept 8, 9. Birthplace (State or Foreign Country) North Carolina 7. Age (In yrs. last birthday, If Under 1 Year Social Security Number Months Days 1 ☑ M 2 □ F 230-58-5431 63 1945 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County 1 ☐ Yes 2√2 No Wicomico Salisbury 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1917 Pine Way 21804 USA 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No Specify: Specify: white 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) roofer bldg contracts 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Robert Simpkins Mary Elizabeth Whitley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 194 Cordova, MD Robert Simpkins III/son 21625 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Litensee Ronald Wade, State Anatomy Board 655 W. Baltimore Street Virector Baltimore, MD 21201 23a. Part L Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CHRENIC OBSTRUCTIVE PULMONARY disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 1 ☐ Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

should be filed within 72 hours after death with the Maryland

Makert Lee Jimokiv Baltimore, Maryland 21215-0036

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Ite Medical Examinar must be mailined at

h and Mental H

t of Health a

permit. Pages Department of Important: If it any injury or c

/Medical

MD

Director

Funeral

Be Completed by

၉

To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran physician attending properties as nse s s been signed by the should be detached

Box 68760.

P.O.

Division of Vital Records,

Physician/Medical Examiner Completed

certificate has b irector, page 2 sh director this After this funeral d e Funeral Director; Affetely filled in by the fun

Be Certification: To 27. Manner of Death

Medical

Registrar

(Check only one) 29b. Signature and title of certifier

5 ☐ Pending investigation

6 ☐ Could not be

1 | Yes 2 PNo

Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

and manner stated

28c. Injury at Work?

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICIZ

P.O BOX 1733 Staisgry us 21802

28d. Describe how injury occurred

D0058410

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day, Year)

31. Date filed (Month, Day, Year) MAR 1 6 2009

To the F

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 10b per FH 8889 3/10/09 TT
State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Vear **Physician** рм 3 8:30 James Earl 11 2009 Turnage /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Balto

9. Birthplace (State or Foreign Country) Towson
If Under 1 Year | If Under 24 Hrs. Gilchrist Center 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 1 M 2 □ F Months 218-46-7377 Director 60 12-4-1948 N.C. Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at XXYes 2□No Funeral Director Baltimore 10f. Zip Code MD N/A10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. 5605 Sinclair Lane 21206 U S Α 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify <u>م</u> Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Tractor Elementary/Secondary (0-12) College (1-4or 5+) 12th grade N/A Trailer Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Turnage Lucy Taylor ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Alvina Turnage-Wife 5605 Sinclair Lane Balto, MD 21206 Item 27 other t 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important; If It any injury or conce. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Zion Cemetery 3-19-2009 Lansdown
22. Name and Address of Facility March East F/H 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee March East F/H Ware 1101 E. North Avenue Balto, MD 21202 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) MONTHS METHSTATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any course to the Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by IRRHOSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HEPATITIS C INFELDON 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed?
Yes 2 No certificate has lirector, page 2 s 1 ☐ Yes 1 ☐ Yes 2 □ No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No Medical Certification: To After this funeral dir 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident s after death.

I Director: Af id in by the fur 1 ☐ Yes 2 ☐ No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific D64395 MARCH 12, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 NORTH CHARLES ST, SUITE 209 BACTIMONE, MD 21204 OUGERMAN, MO 3. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 16

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician ETTA JEAN** TODD 9:30 PM MARCH 13, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 112 SPRY ISLAND ROAD JOPPA HARFORD If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F 220-12-6488 83 Yrs Director 3-5-1926 MARYLAND Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. Counts 10c. City, Town or Location 28a-f show Examiner must be notified at JOPPA MD HARFORD 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Pages 1 and 2 should be filed within 72 hours after death with items 23a 112 SPRY ISLAND ROAD 21085 U.S.A. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2X No Specify: ģ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **ESTON** IRENE D. YEAGLE Α. (KELLER) မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21085 RANDY L. TODD, SR./SON 112 SPRY ISLAND ROAD JOPPA, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date METRO CREMATORY 3-14-09 4 ☐ Donation 5 ☐ Other (Specify) CATONSVILLE 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVENUE 21237 ROSEDALE, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 4 month disease or condition resulting in death) /Medical Due to (or as a cinsequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events The to (or as a consequence of): Examiner or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the a 1 ☐ Yes 2 Z No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? certificate has b irector, page 2 st autopsy perform 1 ☐ Yes 2 ☐ No 2 🗆 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. ours after death.

neral Director: #
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month. Day, Year)

MAR 1 6 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

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32. Registrar's Sig

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within 24 hours a

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

54034

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1,200 PM 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner Ea IMOV 8. Date of Birth If Under 1 Year 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs, last birthday) **Funeral** 1 ☐ M 2 ☐ F Months Days Hours Min Yrs ARU Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1₽Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: <u>6</u> 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19b. Mailing Address Street and Tromber of Fural Troppe All Parts City or Taring ate 77/2 9000 20 19a. Informant's Name/Relationship (Tys. Print) SHAREN GENT MANTER 20b. Place of Dispesition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation / 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part / Enver the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approxima e Interval Betw Onset and Death Immediat Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 9b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

MAR 1 6 2009

onn.

31. Date filed (Month, Day, Year)

ame and address of person who completed cause of death (Item 23a) (Type, Print)

22. Segistrar's Signature B. Jacob

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 12, Daz 2009 Year 17:46 **Physician** John Allen Thompson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 77 1931 Illinois 320-28-8504 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2 X No Bethesda Funeral Director Maryland Montgomery 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code United States 20814 10681 Weymouth Street, Apt. 2A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Completed by 3 ☐ Widowed 4 H Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7 th and Mental Hygiene. 27 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 5+ Federal Government Soil Scientist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Celia Fordyce Harvey Trig Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 27 ls 2137 West University Ave., Stillwater, OK 74074 Pages 1 and 2 ment of Health a Gary A. Thompson / Son permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other: 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. March 15, 2009 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Robert And Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501 23a. Part 1. Ent if the clise set of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus (Fin I disease or condition resulting in death) teriosclerofic oschovasculasclisa **Physician** /Medical ly pestersion Examiner Sequentially list conditions, it any, leading to find edictions. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner physician and the burial-transil Due to (or as a consequence of attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) s been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has e 2 s certificate 2 4NO 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident I Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

law requires that the death certificate be executed 68760, P.O. Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death. within 24 hours are To the Funeral DIr

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar (Check only one)

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

14 desuga

32. Registrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

03/12/2009

Yevery Grachesman, uno

09-02032 Leon F. Thomas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 08118

		1- For State Registrar	Cert	ificate of	Death		Red	ı. No.						
Physici		Decedent's Name (First, Middle,L	_ast)			2	Date of Death		3. Time of Death					
Medical Exam	iner	Leon F. T	'homas				Month March 12, 2	Day Year 2009	0840 hrs					
		4a. Facility Name (if not institution,	give street and number)	4	b. City, Town, or Lo	ocation of Death		4c. County of Deat	h					
		Franklin Square Hospita			Randallstown	1		Baltimore Co	unty					
Funeral		Social Security Number 6.	. Sex · 7. Age (In yrs. las	t hirthday)	If Under 1 Year	If Under 24Hrs.	8 Date of Birth	(MM/DD/YYYY) 9. Bi	rthnlace (State or					
Director		212 00 5220		it birtinday)	Months Days	Hours Min.	o. Bato or Birti	Forei	gn					
Director		212 90 5520 1	X M 2 F 32	Yrs.			Sept.	27,1976	ountry) MD					
	~ ^ ~	Usual Residence of Decedent												
any		10a. State 10b. County		own or Locati	on				10d. Inside City Limits					
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daryland 28a-f show J at once.	용	10e. Street and Number			10f. Zip Code		109	10g. Citizen of What Country?						
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after	by		ced If Yes, Give Year or Dates:	1	Yes 2 X No	specify:	Specify: Bl	ack						
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5-0036 led within 72 Hygiene. I other than the Medical	S	17. Father's Name (First, Middle, La	ast)		18	3.Mother's Name (First, Middle, M							
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21215-0036 auld be filed within 7 Mental Hygiene. marked other than c event, the Medica	0	19a. Informant's Name/Relationship		19b. Mailing				per, City or Town, Stat	e, Zip Code)					
O of bright	0.70	Shawnta Alle	n (sister)	2850) W. Mii]	lherry	St Ba	lto,Md.	21223					
ore, ME ss 1 and 2 s of Health at If item 27 her trainm	* . * .	20a. Method of Disposition			tion (Name of ceme			20c. Location - City o						
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Pag Pag nent ant:		4 Onation 5 Other Spec	offy: // Ar	butus	tus Memorial Pk.Mar.18,2009 Balto,Mo 22.Name and Address of Facility Calvin B. Scruggs Funeral Home									
Baltimore, MI permit, Pages 1 and 2 s Department of Health a Important: If item 27 injury or other trainm:		21 Junature of Funeral Service Lic	censee	22. N	ame and Address o	of Facility	~ D	7 77						
w 52 5 5		Madaini	1 Cherugh	s rune	rai Home	21213								
Physician	-	23a. Part I. Enter the disease, or co	implications that caused the death. I	Do not enter th	e mode of dying, so	uch as cardiac or	respiratory arres	st, shock, or heart	Approximate Interval					
/Medical		failure. List only one cause on							Between Onset and Death					
<u>kaminer</u>		Immediate Cause (Final disease or condition resulting in death)	a. Cardiac arrythr Due to (or as a consequence of):						4					
			b. Hypertensive		zaecular	dicasca								
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):		asculai	discase								
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x 6 h cer tendi	siciar	past 12 months?	4 Pregnant at time of deat	th	ner (Specify)									
Box 687 re death certification the attending red for use as t	ıys	1 Yes 2 No 9 Unkno	g Unknown											
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Division of Vital Records, tal or Attending Physician: The law requir as the death. al Director: After this certificate has been seled in by the funeral director, page 2 should 1	<u>\$</u>	3 Suicide 6 Could n		ne, farm, stree	t, factory, office bui	reet and Number or R ate)	ural Route Number, City							
Division Hospital or Attend 24 hours after death Funeral Director: tely filled in by the	Certification:	4 Homicide determi	(Specify)											
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Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. The Function The Hospital or the the strenging of the Function The Hospital or the Function In the thin the forms as the forms of the Function In the thin the forms or the forms of th	edical	one) 2 Medical Examin	ner:On the basis of examination and manner stated.	d/or investigati	on, in my opinion, o	death occurred at	the time, date a	nd place, and due to t	ne cause(s)					
F × F 5	M	29b. Signature and title of certifier			29c. License	number		29d. Date signed (Mo	onth, Day, Year)					
		his ho	, mi		O.C.M	I.E.		March 13, 2009						
		30. Name and address of person wh	no completed cause of death (Hern C	73a)										
			Medical Examiner 111 F		t. Baltimore M	1D 21201								
					., Daramore, W	0 1								
S	tate trar	31. Date filed (Month, Day Year)	32. Registrar's Signature	BAK	-									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Marvland / Department of Health and Mental Hygieney 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2009 March 12, **Physician** 2:00 A M Vivienne Wang /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's 11415 Bayard Drive Bowie If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number **Funeral** Days Min Year 1 □ M 2 🕅 F China March 95 Director 158-32-7471 Usual Residence of Decedent 10d. Inside City Limits should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b County 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Errorians of perceilled at 1 X Yes 2 No Directo Prince George's Maryland Bowie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20721 11415 Bayard Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ∐Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify ģ 3X Widowed 4 □ Divorced Chinese Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Mental I C.C. Tong I P Yang ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 of Health a 11415 Bayard Drive Bowie, MD 20721 Betty W. Li/ Daughter item 27 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or or 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 3/14/2009 | Glen Burnie, MD Atlantic Crematory 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Juneral Service License 16000 Annapolis Road Bowie, MD 20715 er complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. 23a. Part 1. Enter the disease, er com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a con equence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of) physician a Box 68760, Physician/Medical attending pl 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ Ño 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy To the Hospital or Attending Physician: The certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2, _N6 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation after death.

I Director: Af d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4175 N. Hanson Court Bowie, MD 20715 #203A Andrew Dobin, M.D. 31. Date filed (Month, Day, Year) State MAR 1 6 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieneo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARCH Year 0 llam 10.12 AM /Medical 2009 Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death +GNES BALTIHORE
If Under 1 Year If Under 24 Hrs. HOSPITAL If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days 1 M 2□ F Min. Yrs. Director Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 28a-f show 10d. Inside City Limits event, the Medical Examiner must be notified at Director Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 23a or Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 , i 1 ☐ Yes 2 No þ Specify: rack 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the Mangones. Elementary/Secondary (0-12) College (1-4or 5+) 1 rucke 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be 1 Health and Mental SOV မ Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) -mott St boran 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 Burial 2 Cremation 3 Removal from State Trest let 4 ☐ Donation / B ☐ Other (Specify) 22. Name and Address of Facility rch Fit. 23a. Par I. Enter the disease, or complications that caused the death. Do not enter the more of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause use each line. Approximate Interval Between Onset and Death Immediat C-use (Final disease of condition resulting in death) Physician ESPIRATORY /Medical or as a consequence of): Examiner NEUMONIA Sequentially list conditions, if any, leading to him solute cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 □Yes 2 □ No. 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DEFICIENCY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Vital 2 No 1 ☐ Yes 1 ☐ Yes Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1¥Yes 2 □ No Certification: To 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA this ð 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only ane) 29b. Signature and title of certifie 29d. Date signed (Month Day, Year) 30. Name and address of person who con pleted cause of death (Item 23a) (Type, Print)

State Registrar ARDO

MAR 1 6 2009

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

CNTI

ATCH

BALTIHORE MOZINA

TO

Registrar's Signature

GUS

09-01808 David Wooten Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Marvland / Department of Health and Mental Hygiene

avia vvootori		1- For State Registrar	-	tment of Healtn ar ficate of Death	nd Mental Hy		9. No. 200	9 0812				
Physic Medical Exam			EL W	OOTEN		Date of Death Month March 3, 2	Day Year	3. Time of Death 2016 hrs				
\bigcirc		4a. Facility Name (if not institution, give street and Johns Hopkins Bayview Medical C		4b. City, Town, o Baltimore	r Location of Death		4c. County of Death					
Funeral Director		5. Social Security Number 215-88-4180 6. Sex	7. Age (In yrs. last	Months Day		8. Date of Birth	Foreig	hplace (State or n muntry) MD				
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits				
Aaryland 28a-f show 1 at once.	향	MD BALTIMOR	E		OSEDALE	1		1 Yes 2 XNo				
the Mai 3a or 28	Director	1212 PRIMROSE AVEN	IUE	10f. Zip Code	21237	10	g. Citizen of What Cour					
eath with items 2. ust be n	ıneral	1 XNever Married 2 Married Arme	Decedent Ever in U.S. d Forces?	13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spec in, Mexican, Puerto R		14. Race - Americ White, etc.	can Indian, Black,				
s after de ral", or	by Fun	3 Widowed 4 Divorced If Yes, Give or Dates:	Year	1 Yes 2X No			Specify: W	HITE				
6 72 hours af m "natural"	leted	15. Decedent's Education (Specify only highest Elementary/Secondary (0-12) Colleg	e (1-4 or 5+)	6a. Decedent's Usual Occupa during most of working life			16b. Kind of Business/li	ndustry				
215-0036 be filed within 72 ttal Hygiene. rked other than ent, the Medical	Completed	1 2 17. Father's Name (First, Middle, Last)		CLERK	18.Mother's Name (F	irst Middle M		R STORE				
21215-00 buld be filed wit Mental Hygien marked other c event, the Mo	Be		TEN, SR.		JEAN	Μ.	(PAZD					
	7	ALBERT WOOTEN, SR.	/FATHER	19b. Mailing Address (Street 1212 PRIMR	OSE AVE		er, City or Town, State, $EDALE$, MD	Zip Code) 21237				
Baltimore, MD sernit. Pages I and 2 sh Department of Health and Important: If iten, 27 is rightly or other tranmati		20a. Method of Disposition 1 X Burial 2 Cremation 3 Remova	al from State cren	ce of Disposition (Name of ce matory or other place)		1	20c. Location - City or					
Baltimor permit. Pages 1 Department of 1 Important: If injury or othe		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	GARL	DENS OF FAI: 22. Name and Addres	s of Facility CVA	CH/ROS	BALTIMOR EDALE FUI	RE, MD NERAL HOME				
Physician	_	23a. Part I. Enter the disease, or complications the	at caused the death. Do	1211 CHE	SACO AVE	ROS	SEDALE, MI	21237 Approximate Interval				
/Medical Examiner		Immediate Cause (Final disease a. Athe:	rosclerotio	c cardiovascu			7 - 1 - 2 - 1 1 1 1 1 1 1 1 1 1	Between Onset and Death				
		Sequentially list conditions, b.	as a consequence of):									
	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):										
executed an and al - transit		d.										
7 60, cate be ex- physician he burial -	Medical		23a,2/,pe	erME, g889 3/3	30/09 TT		Loo					
687 ertifi ding e as t		23b. Was decedent pregnant in the past 12 months?	e birth egnant at time of death	2 Fetal death 3	Ectopic pregnanc	у	23d. Date of delivery Month Di	ay Year				
that the death cred by the attended for us	Physician/	1 Yes 2 No 9 Unknown g Un	known	5 Other (Specify) Iting in the underlying cause of		T 00 - D: 14 -						
p. P.O. ires that to signed by 1 be detac	by	- Condition	, to death but not result	ung in the underlying cause (given in Part I.	1 Yes	acco use contribute to the 2 No 3 Proba	ne cause of death? ably 4 Unknown				
tal Records, P.O. cian: The law requires that th certificate has been signed by ector, page 2 should be detach	Completed					24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of				
of Vital Reco	Be Con	25. Was case referred to medical		26.Place	of Death (Check onl	perform 1 ✓ Yes 2	ed? death? No 1 Ves	2 No				
f Of Vital ing Physician: After this certif	ပို	examiner? 1 V Yes 2 No 27. Manner of Death 28a. Da	Inpatient 2 🗸 ER/	/Outpatient 3 DOA	Other Nursing F	lome 5 R	esidence 6 Other:					
	ation:	1 X Natural 5 Pending 2 Accident Investigation	ate of Injury onth, Day,Year)		ry at Work? 28 Yes 2 No	d. Describe ho	w injury occurred					
Division pital or Attent ours after death teral Director:	Certification:			, farm, street, factory, office b	ouilding, etc. 28	f. Location (Str or Town, Sta	eet and Number or Rurate)	Route Number, City				
8 4 5 5		29a. Certifier 1 Certifying Physician: To the b	pest of my knowledge, d	death occurred at the time, da	ate and place, and du	e to the cause(s) and manner as stated	d.				
To the II. within 24 To the Fu	Medical	one) 2 Medical Examiner: On the bas and manne 29b Signature and title of certifier	r stated.	29c. Licens			d place, and due to the 29d. Date signed (Mont					
		Calenna	Tto	O.C.1	M.E.		March 4, 2009					
61		 Name and address of person who completed ca Zabiullah Ali, M.D. Assistant Med 		111 Penn Street, Balti	imore, MD 2120	1						
St Regist	ate rar	31. Date file 1/4 Rh (36 2009 32.	Registrar's Signature	tax		V						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend Item 2	State of M 2 3a per d :	laryland / Depa r.,g889,03/	artment of 16/09dhb	Health a	and Mental I	Hygier Reg. 1	ne •.2009	08122		
			Registrar 1. Decedent's Name (First, Middle, Las			imouto of	Deam	2. Date of		10.2.000	3. Time of Death		
	Physici /Medio		John Rudolph Wa	tson				Febru	ary 2	26, 2009	9:09 AM		
and and	Examir		4a. Facility Name (If not institution, give	street and number	r)	4b. City, Town,	or Location of			c. County of Death	1		
			Prince George's H			Chever	•			Prince Geo			
	Funeral Director		5. Social Security Number 6. S 577 – 52 – 6309	ex 7.A MΩM 2□F	ge (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days		Min. 8. Date of (Month) Jan.	Birth Day, Yea 13,	9. Birth 1939 Wash	place (State or Foreign of try) ington, DC		
	put M		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	cation					0d. Inside City Limits		
	f sho	5	Maryland Prince (looman la		cation					1 X Yes 2 □ No		
	the N	rect	10e. Street and Number	eorge s	Bowie	10f. Zip Code			10a. 0	Citizen of What Cour	ntrv?		
	3a or	<u></u>	1509 Enterprise F	load		20721				.S.A.			
	death	Funeral Director	11. Marital Status	12. Was Decedent	t Ever in U.S. 13.	Nas Decedent of	Hispanic Ori	gin? (Specify Yes or , Puerto Rican, etc.	No-	14. Race - Americ			
36	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23a or 28a-f show ant, the Medical Exercitiver must be notified at	by Fu	1 Never Married 2 Married	1 XiYes 2 □ If Yes, Give	No1959	1 □Yes 2 🛣 No		, a derito riidari, etc.	,	Black, White,			
ö	hours tural"	q pe	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:		dent's Usual Occu	mation		104	Specify: Blac			
15	in 72 in "na nedic	Completed	(Specify only highest gra	de completed)	(Give	kind of work done OO NOT use retire	e durina most	of working	10	6b. Kind of Business/Industry Food Services			
212	d with giene gr tha	mo	Elementary/Secondary (0-12)	College (1-4or 1	Sel Sel	lf Emplo	yed		- 1	nsurance l			
р	e filer al Hy dothe	Be	17. Father's Name (First, Middle, Last)				1	r's Name (First, Mid		en Surname)	•		
yla	Ment Ment arkec atic e	2	John Randolph Wat	son			Ann	ie Lee Wi	Lee Willis				
Maryland 21215-0036	12 shuh and hand 7 is m		19a. Informant's Name/Relationship (-	or Town, State, Zip	Code)		
e,	1 and Healt em 27		Maria-Luisa Watso	m (wile)				., Bowie,		20721 Location - City or To	uun Stata		
Ď	ages ent of t: If it y or o		1 ☐ Burial 2 🛣 Cremation 3 🗆		20b. Place of Dispo cemetery, cren Metropoli	tan Cres	ace) ;			Lexandria,	•		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment must be notified at once.		4 ☐ Dopation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen			, 11							
m	permi Depar Impor any Ir		Lemmes ()	ellou	Mo	Lendon 1 5 Merce:	Memori r St.,	al Funera Washingt	1 Horon, 0	ne SA 30673			
			23a. Part 1. Enter the disease, or comp	olications that cause	ed the death. Do not ent	er the mode of dy	ing, such as	cardiac or respirator			Approximate Interval Between		
1	Physician		Immediate Cause (Final disease or condition	a	- F 7 - W	Cardiac .	AFFLIN				Onset and Death		
4	/Medical Examiner		resulting in death)	Due to (or as	s a consequence of): Hypert	ension							
		ē	Sequentially list conditions,	b. Due to for as	s a consequence of):								
	uted d ansit	Ë	causé. Enter Underlying Cause (Disease or injury that initiated events										
oʻ	e exec an an rial-tr	Еха	resulting in death) Last	Due to (or as	s a consequence of):								
8760,	cate be executed physician and the burial-transit	dical		,d									
	ertific Jing p	Mec	IF FEMALE:	00 - 1/			_						
Box	death certific e attending p ed for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 ☐ Fetal death 3 ☐	Ectopic pregnan Other (specify)	псу			23d. Date of delive Month	ery Day Year		
0	0 0	ysic	1 □Yes 2 □ No 9 □ Unknown	9 Unknown	at time of death 5	Other (specify) _			_				
œ.	requires that the peen signed by th hould be detache	by Pt	Part II. Other significant conditions of	ontributing to death t	but not resulting in the ur	iderlying cause gi	iven in Part I.	23e. D	id tobacco	use contribute to the	ne cause of death?		
ğ	w require been sig should b	ed b						1	□Yes	2 ☐ No 3 ☐ Prob	ably 4 Unknown		
မ	aw as b	Completed						24a. W	/as an utopsy	24b. Were auto	psy findings available npletion of cause of		
<u>~</u>	The ate h page	Com						l po	erformed?	/ death?			
Vita	Physician: The ribis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hoosital		Tax		of Death (Check on	ly one)				
o	S S E	<u>P</u>	1 ☐ Yes 2 ☑ No 27. Man or of Death	Hospital: 1 ☐ Inpati 28a. Date of Inj	ient 2 ER/Outpatien ury 28b. Time of	t JUDON				6 ☐ Other (Specify	y)		
on	ding h. After fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Da			ork? ⊡Yes 2.∐.N		be now inj	ury occurred			
Division	Attending r death. ector: Afte by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be		jury - At home, farm, stre tc. (Specify)		1100 200	28f. Locatio	n (Street a	and Number or Rura	l Route Number,		
Ö	tal or s afte al Dire ed in l	Certification: To	4 ☐ Homicide determined	building, e	tc. (Specify)			City or	Town, Sta	te)			
\	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral v		(Check only 2 Medical Exam	/sician: To the best	of my knowledge, death of examination and/or inv	occurred at the t	time, date an	d place, and due to	the cause	(s) and manner as s	tated.		
	the h	Medical	29b. Signature and title of certifier	and manner st	tated.				_				
	5 ₩ 6		29b. Signature and title of certifier			29c. Licen:			29d. L	Pate signed (Month, I	2000		
			30. Name and address of person who	completed source of	death (Item 220) (Time 5		743	6		yeu jo	2009		
			Dr. Jennifer W	hutfield	Pellows	3001 F	to5DIt	al Drive	CI	heverly.	UD 20785		
	Sta		31. Date filed (Month, Pay, Year)		rar's Signature		,	4					
	Registr	ar	MAR 162	009 De	wa A s	harled							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 20 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 2009 March 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Balhmore aint Agnes Hospita If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 1 □ M 2 🛛 F Months Days Hours Min Country 224-68-4658 72 Yrs. February Virginia Usual Residence of Decedent 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No NIA altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21201 batehouse 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No If Yes, Give Year or Dates: Specify Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) touse wife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2860 Nothingham - daughter batchouse Kalto 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/09 Baltimore 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Addres of Facility Funeral Home Heights Balto MD 21207 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hemorrhagic Cerebro Vascular Accident Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown

Physician /Medical Examiner

permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any Injury or other trau

Physician

Examiner

Funeral

Director

and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. In 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

þ

Completed

Be ပ

Examine The law requires that the death certificate be executed

attending physician and for use as the burial-tran

cate has been signed by the a page 2 should be detached for

certificate

After this

To the Funeral Director: After the completely filled in by the funeral

P.O.

Records,

of Vital Physician:

Division or Attending

Hospital e Funeral I

ALL

Physician/Medical

þ

Completed

Be

Certification: To

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE:

Part II. Other significant	conditions contributing to d	leath but not resulting in the	underlying cause given in Part
		· · · · ·	

1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy 1 □ Yes 2 **X** No

23e. Did tobacco use contribute to the cause of death?

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No

25. Was case examiner	referred to medical
1 ☐ Yes	2 No
27. Manner of	Death

5 Pending investigation 6 ☐ Could not be

Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29	a. Certifier
	(Check or
	one)

1 🔀 Natural

3 Suicide

4 Homicide

2 Accident

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

D0064762

29d. Date signed (Month, Day, Year) March 11, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohammed

900 S Caton 32. Registrar's Signature

MD

Balhmore, MD 21229

26. Place of Death (Check only one)

State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registrar 08124 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Year **Physician** 4:50 PM ames March 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2900 Belmont saltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | \(\Lambda\) (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign
Country) **Funeral** August 10, 1942 Months 1 M 2 □ F 223-54-3495 66 Yrs. Director Virginia Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examination of the motified at Director 1 Wes 2 □ No Da tt more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 2900 Belmont USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yes If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. and 2 should be filed within 72 hours after dealth and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 Nidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) anitor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aue of Health Walters - daughter Richwood Balto 1010 Antoinette 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State permit. Page:
Department o
Important: If
any injury or
once. ō 17/09 Baltimore, 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funcial Howell Balto MD 21207 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** Sylveticete echo disease or condition resulting in death) /Medical Du to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) s been signed by the should be detached 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy certificate performe 2 5 2 100 1 □ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) After th funeral Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division Hospital or Attending 5 Pending investigation Jepital ...
4 hours after de...
--eral Director: Ane 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ال 24 hour. الله Funeral Dir. الله filled in by determined 4 Homicide Prestifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 03-13-2009 DOS74310 12

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mennuer

22. Registrar's Signature

S. Greinest Baltimure MO 21201.

Funeral Director

	State Registrar	- (First Middle I -	-41		Certificate of	Death	· · · · · · · · · · · · · · · · · · ·	Reg. No	2009	0812			
n		ne (First, Middle, Las Cecilia Wil	•				2. Date of De Month	Month Day Year					
al er	4a. Facility Name	(If not institution, give	e street and number)		4b. City, Town,	or Location of Dea	ath	4c. County of Death					
			E HOSPITAL			edale r If Under 24 Hr	- 10 Date (Di	Bactimore					
	5. Social Security I		ex 7. Age	(In yrs. last b	Yrs. Months Day:			tn 1 <i>y</i> Yea <i>r)</i>	1945 Mar	hplace (State or Forei yland			
	Usual Residence												
_	10a. State	10b. County			wn or Location					10d. Inside City Limit			
Director	Maryland	Baltimore	e	Baltin						1 □Yes 2 🗖 N			
	10e. Street and Nu	Road Apt. D			10f. Zip Code 212			log. Ci	tizen of What Co	untry?			
Funeral	11. Marital Status	Noda Apt. D	12. Was Decedent Ev	ver in U.S.	13. Was Decedent of	Hispanic Origin?	(Specify Yes or No		14. Race - Ame	rican Indian,			
		ried 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		If Yes, specify Cu	ıban, Mexican, Pue	erto Rican, etc.)		Black, White				
d by	3 🗆 Widowed	4 Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 🕅 💘	o Specify:			Specify: White				
Completed	(Spe	15. Decedent's Ed ecify only highest gra		16	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)								
dmo	Elementary/Sec	ondary (0-12)	College (1-4or 5+)) -	Tax Investigato			S	State Of M	aryland			
Bec	17. Father's Name	(First, Middle, Last))				ame (First, Middle		en Surname)				
To B	Gordon Ma	lone		Elizabeth Satterfield									
_		Name/Relationship (19	9b. Mailing Address (Stre					Zip Code)			
		.ams / Husbar	nd		15 Arlen Road	•							
	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - C												
	4 Donation 5 Other (Specify) Hilltop Service Corp. 3/12/09 Towson Maryland												
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214												
_	23a, Part 1, Enter	the disease, or com	plications that caused t	the death. De	o not enter the mode of d				N 21214	Approximate			
	shock, or he Immediate Cause	eart failure. List only e (Final	one cause on each line).						Interval Between Onset and Death			
	disease or condit resulting in death		a. S. I. F. Due to (or as a	•	e of):								
	Sequentially list conditions, b. 15 chemic bowel												
iner													
Examine	that initiated even resulting in death	IS E	C. Due to (or as a	consequence	consequence of):								
Ш	Suc to (of as a consequence of).												
C													
edica										. Date of delivery			
n/Medica	IF FEMALE:	nt pregnant	23c. If yes, outcome o						23d. Date of del	livery			
sician/Medica	23b. Was decede in the past 1 1 ☐ Yes 2	2 months?	1 ☐ Live birth 2 4 ☐ Pregnant at	E Fetal dea					23d. Date of del Month	livery Day Year			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 08126 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Charce **Physician** watt 22.04 M /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner adventist Hosp Park montgorne akoma | If Under 24 Hrs. | 8. Date of Birth | Hours | Min. | (Month, Day, 7. Age (In yrs. last birthday) 84 Yrs. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1**9** M 2□ F Months 255-28-677 **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Mcolcal Expension in ust be not the day Wasning N∰Yes 2 No Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 6th 2001 Street Northeas Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Types 2 □ No If Yes, Give Year or Dates: 1945 ~ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene important: If Item 27 Is marked other than any Injury or other traumatic event, the Maonee. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fannie Wrigh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5920 6th St NE wasnington, DC 20011 Watts Anna 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State Brentwood, MD Fort Lincoln cemetal 03/13/09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of allity 21. Signature of Funeral Service Licenses Bianchi-814 Uponyr St NW Wash., DC 20011 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Division of Vital Records, P.O. Box 68760, ✓ Due to (or as a consequence of): for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear Day 5 ☐ Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Minknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 □Yes 2 🖾 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 Pending investigation 1 🔀 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Coertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. the

State Registrar 31. Date filed (Month, Day,

29b. Signature and title of certifier

of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

KWAY

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	1 - State Registrar Certificate of Death										Reg. No.	009	0.8	127			
Physicia	an	1. Decedent's Name (F	First, Middle, Last)	, 1							2. Date of De Month	ath Day	Yea					
/Medic	al	Marsha	a11 W	1991ns			4h Cih	Town, or	Location	of Dogth	Feb	28			(a VM			
Examin	er	4a. Facility Name (If no			al Ca	nter		Him		or Death		40.0	ounty of De	ain				
Funeral Director		5. Social Security Num 215-34-973	ber 6. Sex			last birthday) 4 Yrs.	- Company	r 1 Year	If Under Hours	24 Hrs. Min,	8. Date of Bir (Month, Di Aug 15	a <i>y</i> , Year)		irthplace (Sta Country)	te or Foreign unk			
land ow		Usual Residence of De	ecedent 0b. County	unk	10c. Cit	y, Town or Lo	cation						unk	10d loside	City Limits			
Ba-f sh	ector										- 1	10		1 □ Y				
h with th	Funeral Director	10e. Street and Number	er			unk	10t. Zi	p Code			unk	10g. Citiz						
tems terms	uner	11. Marital Status		2. Was Decedent Armed Forces?		s. unk 13. \	Was Dece If Yes, spe	edent of His	spanic Or n, Mexicai	igin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	D- 1-			,			
ours afte al", or li Evamin	þ	1 ☐ Never Married 3 ☐ Widowed 4 ☐		1 □Yes 2 □ If Yes, Give Year or Dates:	No		1 □Yes	2 X No	Specify:			3	Specify: W	hite				
in 72 ho	Completed	(Specify	5. Decedent's Educ only highest grade	completed)			kind of w	ual Occupa ork done d use retired)	uring mos	t of work	_{ing} unk	16b. Kin	d of Busines	3. Time of Death Year 2009 9. Birthplace (State or Foreign Unik) 9. Birthplace (State or Foreign Unik) 10				
ed withi lygiene. ner thar it, ib		Elementary/Seconda unk	un	College (1-4or t	5+)						/F' 11'-11'							
ld be fill fental H ked oth	To Be	17. Father's Name (Fir.	st, Middle, Last)				unk 18. Mother's Name (First, Middle, Maiden Surname) u							unk				
2 shour and M	_	19a. Informant's Name					-					-		, Zip Code)				
1 and Health tem 27		University 20a. Method of Dispos		land Med	20b. F	Place of Dispo	sition (Na	me of	1		Baltimo Date							
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatte event, the "Natical Eventhar mail be notified at once.		1 ☐ Burial 2 ☐ C 4 ☐ Donation 5	Cremation 3 ☐ R	in stat	:e	cemetery, cren	natory or	other place	-									
Depar Impor any In		21. Signature of Euner	ral Service License	lade Vir	ector	The state of the s						. Balı	timore	Stree	t			
		shock, or heart failure. List only one cause on each line. Interval Between Onset and Death																
Physician /Medical		disease or condition resulting in death)	a a	Sepsion Due to (or as		uence of):												
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician//										3d. Date of d Month		Year					
s that t gned by e detac	by Ph	Part II. Other significa	ant conditions con	tributing to death b	out not res	ulting in the u	nderlying	cause give	n in Part I	l.	23e. Did	tobacco us	e contribute	to the cause	of death?			
require been si hould b	eted											Yes 2						
The law cate has I page 2 s	Completed										24a. Was auto perfo 1 □Yes		prior to death	completion (
iclan: Sertific ector,	Be (25. Was case referred examiner?	L	oenital:				Otho		e of Deat	h (Check only	one)						
Physical direction	5	1 Yes 2 No 27. Manner of Death		ospital: 1 XInpati 28a. Date of Inj		ER/Outpatier		OA Othe	4 🗆 N	ursing Ho	ome 5 Res			pecify)				
ending eath. or: Afte the fune	cation	1 Natural 2 Accident	5 ☐ Pending investigation	(Month, Da	ay, Year)	Injury	М	Work 1 □ \	? Yes 2□	No	200.000.00							
Ital or Att Irs after d ral Direct led in by	Certification: To	3	determined	28e. Place of In building, e	jury - At ho tc. <i>(Specii</i>	ome, farm, str	eet, factor	ry, office			28f. Location (City or To	(Street and wn, State)	Number or	Rural Route N	lumber,			
ne Hosp n 24 hou ne Fune, pletely fil	Medical	29a. Certifier 1 (Check only 2 one)	Certifying Phys	sician: To the best ner: On the basis and manner st	of examina	owledge, death ation and/or in	h occurre vestigatio	d at the tim n, in my op	ne, date a pinion, de	nd place, ath occur	and due to the red at the time	cause(s) , date and	and manner place, and d	as stated. ue to the caus	;e(s)			
To th To th comp	M	29b. Signature and title	e of certifier	>				c. License		7				nth, Day, Year				
		30. Name and eddress	s of person who co	mpleted cause of		m 23a) (Type,	Print)	+1 4	410		nore in	tebro	lary ?	-8,200	7			
		Tania	Conda	rso	1	22 5.	Gree	ne S	it B	altr	nore , n	10 2	1201					
Sta	ite	31. Date filed (Month,	Day, Year)	32. Regist	rar's Signa	ature	2											

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death March **Physician** nara 3 2009 4c. County of Death /Medical City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner** Baltimore City The Johns Hopkins Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Months Days | Hours | Min. 7. Age (In yrs. last birthday) 5. Social Security Number 1 M 2 Dx **Funeral** 62 1947 MD Jan 18 215-48-4326 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County show ms 23a or 28a-f sho must be notified at Carrol1 Woodbine 1 Yes 2X No MD Director 10g. Citizen of What Country? 10f Zin-Code 10e. Street and Number USA 21797 1544 Hoods Mill Road items 23a Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. 1 Yes 2 If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 XMarried 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify white þ 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Carroll County College (1-4 or 5+) Elementary/Secondary (0-12) Government secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cordelia Marie Fleming Harold Goodwin ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1544 Hoods Mill Rd., Woodbine, MD 21797 Norman Zepp Sr. (spouse) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Woodbine, MD Morgan Chapel Cem. 3-18-09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Parge Häught Sterbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Heart Failure immediate Cause (Final 1 year **Physician** disease or condition resulting in death) Due to (or as a consequence of): /Medical Pulmonary Hypertension luear Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician at 1 for use as the burial-Physician/Medical IF FEMALE: 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death Day in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 🗌 No 1 Tyes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 12 Inpatient 2 ER/Outpatient 3 DOA

Division of Vital Records, P.O. Box 68760,

Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only one)

29c. License number

RES-000

within 24 hours after death.

To the Funeral Director: After this certificate has been sig completely filled in by the funeral director, page 2 should I

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

2. Registrar's Signature MAR 16 2009

		For State Registrar	State	of Maryla	nd / Depa <i>Ce</i>	artment rtificate	of He	ealth a <i>eath</i>	and M	lental Hy	/giene Reg. No		09	081	29	
		Decedent's Name (First, Middle	e, Last)							2. Date of D	eath			3. Time of Do	eath	
Physicia		Laurence	100	A . 1	reus					Month	Da - 27			0700	1 M	
/Medic Examin		4a. Facility Name (If not institution	n, give street and n		il ews	4b. City,	ſown, or l	Location of	f Death	Corna	7 40			- 100 /-		
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Funeral Director		5. Social Security Number 536-09-1592	6. Sex 1 M 2 ☐ F	7. Age (In yr	s. last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of B (Month, D	rth ay, Year) 7 19	1Ω	Cour	itry)	_	
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be motified at other.	by Funeral	11. Marital Status 1 □ Never Married 2 Marrian 3 □ Widowed 4 □ Divorced	Armed F	2 No Give		Was Decedo If Yes, spec 1 □ Yes 2	_ /	spanic Orig n, Mexican, Specify:	gin? (Spe , Puerto	ecify Yes or N Rican, etc.)	0-		, White,	etc.		
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of He item		20a. Method of Disposition			Place of Dispo	sition (Nam	e of her place	,) :	D	ate	20c. L	ocation - 0	City or To	wn, State		
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To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	⊒Ectopic pr ⊒Other (spe							year 2009 CRSS A M unty of Death Contgomery 9. Birthplace (State or Foreign Country) Washington 10d. Inside City Limits 1 Yes 2 No 10f What Country? ted State Race - American Indian, Black, White, etc. ecify: White of Business/Industry search mame) Wise 20m, State, Zip Code) mg, Md. 20906 ion - City or Town, State exandria, Va. 4. Md. 20882 Approximate Interval Between Onset and Death Month Day Year contribute to the cause of death? 10 3 Probably 4 Unknown 10 3 Probably 4 Unknown 11 Yes 2 No 12 No 13 Other (Specify) Courred 14 Other (Specify) Courred 15 Other (Specify) Courred 16 Manner as stated. 16 Ace, and due to the cause(s) 17 Agree (Month, Day, Year) 18 Agree (Month, Day, Year) 19 Agree (Month, Day, Year) 19 Agree (Month, Day, Year) 10 Agree (Month, Day, Year) 10 Agree (Month, Day, Year)						
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical C	29a. Certifier 1 Certifyin (Check only one) 2 Medical	Examiner: On the	he best of my k basis of exami	nowledge, dea nation and/or ii	th occurred anvestigation,	at the time in my op	e, date an inion, deat	d place, th occurr	and due to th ed at the time	e cause(s , date an	s) and mai d place, a	nner as s nd due to	tated. the cause(s)		
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10	\	foll barrier MD MD 060335 February 27, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										-				
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	201		I.S.													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Reg. No. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Lest) 2. Date of Death Month **Physician** Goldie Deona Andrew 2009 11:30 PM Feb /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Fecility Neme (If not institution, give street end number) Examiner Frederick Emmitsburg 305 W. Main Street if Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Aug 26, 1918 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. lest birthday) **Funeral** Months Pennsylvania 1 □ M 2 K F 90 214-16-0529 Yrs. Director Usual Residence of Decedent deeth with the Maryland 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County item 27 is marked other then "netural", or items 23a or 28a-f sho other traumatic event, the Madical Examinar must be notified at Emmitsburg 1 Yes 2 □ No Frederick Maryland Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 21727 305 W. Main Street USA Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours efter of Depertment of Heelth end Mental Hygiene. Important: If Item 27 is marked other then "netural", or Item eny Injury or other traumatic event, the Medical Expariment eny Injury or other traumatic event, the Medical Exparimen 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 X No Specify: 3altimore, Maryland 21215-0020 β 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Ellen Snyder John Michael Manning 2 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 305 W Main St, PO Box 130, Emmitsburg, MD 21727 Nancy L. Tyler, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 03/02 1 Buria! 2 ☐ Cremation 3 ☐ Removal from State Cascade, MD Germantown Bethel Cem 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Myers-Durboraw Funeral Home 22. Name and Address of Facility 210 W Main Street, Emmitsburg, MD 21727 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, br heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) CORONARY ARTERY Examiner Due to (or as a consequence of) Examiner sician end burial-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): After this certificete hes been signed by the ettending physician funeral director, page 2 should be detached for use es the buria Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown DIABETES MELLITUS δ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed TYPERTENSION 1 TYes 2 WNo 1 □ Yes 2 □ No To the Hospital or Attending Physicien: within 24 hours efter death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ▶ Residence 6 ☐ Other (Specify) P 1 Yes 2 No 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28c. Injury et Work? Certification: 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and menner es stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piace, and due to the cause(s) and manner stated. 29a. Certifier Medical

WJL 3

> State Registrar

KRABLW MD 423 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

29b. Signature and title of celtifier

5. WASHINGTON 32. Registrar's Signature

29c. License number

MODISTETE

29d. Date signed (Month, Day, Year)

02-26-09

GETTYIBURL, PA 17325

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Rea. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician 7:45 a. Delton M. **Allen** 2009 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park Washington Adventist Hospital Montgomery Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Und Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min 1**X** M 2□ F 58 Piedmont, WV **Director** Aug. 17,1950 233-84-0832 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ▼Yes 2 No Director MD Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Numbe 6 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any liquy or other traumatic events. items 23a Funeral 9203 New Hampshire Avenue 20904 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. þ Specify: 3 Widowed 4 Divorced **Black** Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Advertising Newspaper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Adam Arthur Allen Lillian Pauline Washington ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorene F. Allen/Sister 55 Lincoln_Street Keyser, WV 26726 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Potomac Memorial Gardens 2009 Keyser, WV 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Smith Funeral Home 85 S. Main Street Keyser, WV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause — each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or sen, ing Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician. The law requires that the death certificate be executed burial-tran Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 I Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 ☐ Yes 2 X No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manne eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 atural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office uilding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours aft ie Funeral Di bletely filled ir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2 and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific

State Registrar

31. Date filed (Month, Day, Year)

MAR 1 6 2009

DHMH 17 Rev 1/2001

ress of person who completed cause of death (Item 23a) (Type, Print)

legistrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 3 per doc g889 3-18-09 vt

2 State of Maryland / Department of Health and Mental Hygien? 1 9 08132

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uner vast	1	1. Marital Status	danida d	Armed F		n U.S.	 Was Decedent of If Yes, specify Cu 	Hispanic Orig ban, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	10-	 Race - Americ Black, White, 	
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self Ex	$\mid \cdot \mid$	15. Dece	dent's Ed	ducation		16a. De	cedent's Usual Occ	upation		16b. Kind	d of Business/In	
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2 5 4	1	7. Father's Name (First, Midd	dle, Last))				18. Mother	r's Name (First, Middl	le, Maiden S	iumame)	
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item 27 is marke other traumatic	_	GERALDINE HAI Oa. Method of Disposition	<u> </u>	COUSIN			b SILVERI	INE DR	IVE, FAIRE	7	ATLON, ation - City or To	
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nlury .	1	`4 ☐ Donation 5 ☐ Other 21. Signature of Funeral Serv			P	POHICK	CEMETERY 22. Name and Add		2/13/2009	LORT	ON, VA	
Importal any inju	1	21. Signatures, unioral Solv	TA/	200	/		MOUNTCAST	LE FUN	ERAL HOME			0101
		23a. Part1. Enter the disease	or com	plications that	caused the d				ROAD, WOOD		E, VA 2	Approximate
		shock, or heart failure. I Immediate Cause (Final	List only	one cause on	each line.		. 1.1	3.	,			Interval Between Onset and Death
ician dical	10	disease or condition resulting in death)	-	a	MINION	ncequence of):	monlis	m				11 days
niner			- 1	1	(Or as a con-	iseque io oi).	1	1	1 /	1	_	
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	i	Sequentially list conditions, f any, leading to immediate	J	b. Due to	(or as a con	equence of):	un trac	ture	right	Knex	0	
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			For State	State of	Maryland		artment of Hi rtificate of L			Jiene. U U J leg. No.	00133
			Registrar 1. Decedent's Name (First, Midd	lle, Last)			11110010 01 2		2. Date of Dea	th	3. Time of Death
	Physicia	ın			Dov	1.			Month Feb. 2	Day Yea	7:30 a
	/Medic		Joyce 4a. Facility Name (If not institution	Lorraine		T.G.	4b. City, Town, or	Location of Death		4c. County of De	
1	Examin	er	Sunbridge C				Elkto	n.		Cecil	
	Funeral		5. Social Security Number		7. Age (In yrs. las	t birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day		Birthplace (State or Foreign Country)
	Director		155-16-3074	1 ☐ M 2 ☐ XF	86	Yrs.	Months Days	Hours Min.	Dec.	4,1922	Newark, NJ
	P		Usual Residence of Decedent		ton City 3	Farm and					10d. Inside City Limits
	with the Maryland a or 28a-f show		10a. State 10b. County	У	10c. City, 7	lown or Lo	ocation				1 ☐ Yes 2 ☑ No
	Ba-f s	cto		Castle		Newa				10- 00	
	ith th	i d	10e. Street and Number				10f. Zip Code			10g. Citizen of What	Country?
	ath w	Funeral Director	64 Stardust			10	1970		acity Voc as No	USA	merican Indian,
	ltems	nue	11. Marital Status	Armed Fo		13.	Was Decedent of Hi If Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	Black, W	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes Giv	ates:		1☐ Yes 2☐No	Specify:		Specify:	Mhite
21215-0036	72 hours after death with the Maryland "neturel", or Items 23a or 28a-f show adical Examiract must be invitilled at	ed	15. Decede	nt's Education		16a. Dece	dent's Usual Occupa	ation		16b. Kind of Busine	
15	- 20	Completed	(Specify only high Elementary/Secondary (0-12)	est grade completed)	-4or 5+)	(Give life.	kind of work done of DO NOT use retired,	luring most of work)	king		
212	yene.	Eo	1 2	2	401 54)	S	ecretary	7		Educati	Lon
	be filed ital Hyg id othe event,	Be C	17. Father's Name (First, Middle	, Last)			Jonesda	18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
<u>la</u>	uld be Aenta rked tic ev	To B	Thomas Dyer					Olive	Hill		
Maryland	s 1 and 2 should be filed withir f Health and Mental Hygiene. item 27 is marked other then other treumetic event, the M		19a. Informant's Name/Relation	ship (Type, Print)		19b. Mail	ng Address (Street a	and Number or Rui	ral Route Numbe	r, City or Town, State	a, Zip Code)
	무를 2		Adelbert D.	Boyle- H							
Baltimore,			20a. Method of Disposition ¶ Burial 2 ☐ Cremation	3 Demoval from	cen	netery, cre	osition (Name of matory or other place	e)	Date	20c. Location - City	or Town, State
Ĕ	Page nent o ant: If ury or		`4 □Donation 5 □ Other (Specify)	1001	oria	e Vetera 1 Cemete	ory; J/	3/2009	Bear, T	ЭE
alti	permit. Pa Departmen Importent: eny injury		21. Signature of Fulledal Service	e Lynnight	- CC04	12 2	2. Name and Addresses Fu	s of Facility	Jome of	Nowark	
Ω	8 9 T 2 9		Kelet	ノントト	1		053 Pula	aski Hid	thway.	Newark.	DE 19702
-10			23a. Part1. Enter the disease, on shock, or heart failure. Lis	or complications that o st only one cause on e	aused the death. ach line.	Do not en	ter the mode of dying	g, such as cardiac	or respiratory an	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	(Perebror	asa	clas Ac	archat			Onset and Death Unknown
	/Medical		resulting in death)	Due to	or as a conseque			ndostilinini.			Unknown
	Examiner		Sequentially list conditions,	b	Demes	tie					Unknown
	р =	iner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	UF as a out seque	nea ofly:					
	and trans	Examiner	that initiated events resulting in death) Last	C. Dun to	or as a conseque						
50,	oe ex		, , , , , , , , , , , , , , , , , , , ,	Due to	or as a conseque	ince ory.					
68760,	Attending Physicien: The law requires that the death certificate be executed in death. si death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	edical		d							
	ertific ding p		IF FEMALE:	23c If yes out	come of pregnance	:v				23d. Date of	deliven
Вох	eath certi	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live t	oirth 2 Fetal d	leath 3	☐Ectopic pregnancy ☐ Other (specify)			Month	Day Year
	he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unkn		5					
P.0	law requires that the de as been signed by the a 2 should be detached	'Ph	Part II. Other significant condi	tions contributing to d	eath but not result	ing in the	underlying cause give	en in Part I.	23e. Did to	bacco use contribute	e to the cause of death?
ds	uires sign id be	d by							1 🗆 Y	res 2□No 3□	Probably 4 dunknown
Ö	v req beer shou	Completed							24a. Was	an 24b. Were	autopsy findings available to completion of cause of
Rec	ne lav has ge 2	mp							autop	rmed2 death	1?
a	ticien: Th certificate rector, paç	e Co	25. Was case referred to medic	201				OC Place of Doo	1 ☐ Yes		es 2 No
Division of Vital Records,	sicie certi irecto	00	examiner? 1 Yes 2 No	Hoenitals	Inpatient 2□E	P/Outpatie	ent 3 DOA Oth			dence 6 Other (S	inecifu)
of	ding Phys	: To	27. Manner of Death			28b. Time				now injury occurred	poony
on	th. : Afte	tion	1 Natural 5 ☐ Pend 2 ☐ Accident inves	ting (Mon stigation	in, Day Year)	Injury		K? Yes 2 □ No			
/isi	Attendi r death. sctor: A by the fu	ifice	3 ☐ Suicide 6 ☐ Coul	mined 200. Flace	of Injury - At hom	ne, farm, s	treet, factory, office		28f. Location (S City or Tow	Street and Number of	Rural Route Number,
Ö	afte safte	Sert	4 Homicide	bulla	ing, etc. (Specify)				Only or you	m, olale)	
	Hospitel or 24 hours afte Funerel Dir tely filled in	la:	29a. Certifier 1 Certify	ing Physician: To the	best of my know	ledge, dea	th occurred at the tin	ne, date and place	, and due to the	cause(s) and manner	as stated.
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical Certification:	(Check only 2 Medic	al Examiner: On the band man	ner stated.	on and/or i					
	To the within 2 To the complete	Σ	29b. Signature and tipe of certif	_			29c. Licens			29d. Date signed (M	*
			1 Deele	Cers Mi)			100	023322		2.27.0	X009
_	2		30. Name and address of person		se of death (Item :	23a) (Type	(Dei-A)	ekten	Mr a	621	
_			U.J. SACHDE	EV MD, 10	26 A, E	Hig	SUT E	eklen	111) 21	421.	
	Sta		31. Date filed (Month, Day, Yea	32. F	Registrar's Signatu	Ire	. 1				
	Regist	air	MAR 032	UUS Denew	w 13. 7	gark	180				

Division of Vital Records, P.O. Box 68760, within 24 hours a

NO D0047711 February 26, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite #3 ELKTOW 304-306 North Street MARTHAND 21921 DAVID GAK-EL 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAR 03 2009

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Pay 27,

4b. City, Town, or Location of Death

Frederick

08135

3. Time of Death

6:30 A M

2009

4c. County of Death

Frederick

Physician
/Medical
Examiner

1 - For State Registrar

Lewis

Michael

a. Facility Name (If not institution, give street and number)

8933 Yellow Springs Road

Burall

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment rust be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	5. Social Security No. 216–48–68		6. Sex 1 ☑ M 2 □ F		(In yrs. last birthday) 54 Yrs.		r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi Apr 11	rth lay, Year	954 M	. Birthplace Country) arylar	(State or Foreign
	Usual Residence of	Decedent												
	10a. State	10b. County		10c. City	c. City, Town or Location 10d. Inside City Limi									
ğ	MD	Frede	rick	Fred	erick								1	□Yes 2∏ No
Se l	10e. Street and Nun					10f. Zi	p Code				10g. Ci	tizen of Wha	at Country?	
ra D			rings Road	đ		21	702				USA	A		
Completed by Funeral Director	11. Marital Status 1 □ Never Marrie		ried Armed F	2 ⊠ No ive	If Yes, specify Cuban, Mexican, Puerto Rici					ecify Yes or No Rican, etc.)	0-	Black,	American In White, etc. White	ndian,
ted b	3 Widowed	15. Deceder	Yeer or I	Dates:	16a. Decedent's Usual Occupation 16b. Kind of									y
mple	Elementary/Seco		completed) College (1-4or 5+)	life. I	DO NOT I	ork done ise retire	during mos d)	ST OF WOFKIF	ng	De	etail	Sales	
ပ		(F)	1 4)		Manag	leT.		10 Moth	or's Nama	(First, Middle	1		bares	
To Be	17. Father's Name (Henry Lo									/ Eliza			ter	
	19a. Informant's Na Betty M.	Bural	ship <i>(Type. Print)</i> 1/mother		19b. Mailir 8933	ng Addres Yell	s (Street OW S	and Numb pring	er or Rura S RO	ad Fred	ber, City deric	or Town, St Ck, MD	ate, Zip Cod 21702	^(e)
	20a. Method of Disp 1 ☐ Burial 2	State W.	lace of Dispo emetery, crer Arunde	sition (Na natory or	me of other pla	ce))3/09		ocation - Ci		State		
	4 ☐ Donation 21. Signalue of Fu			1	GC	ing :	ntane	screil	ation	n Servi	ce	P.O.	Box 78	
_	den	elly I	- Halit									arksvi		MD 21029 proximate
			r complications that t only one cause on			er the mo	ae or ayı	ng, sucn as	s cardiac c	or respiratory	arrest,		Inte	erval Between set and Death
	Immediate Cause (Final disease or condition Cardiac Arrest													
	resulting in death)			(or as a conseq										
	Metastatic Laryngeal Cancer													
ner	Sequentially list conditions, firmy, leading to immediate cause. Enter Underlying Cause (Disease or injury but initiated exercise.									4				
Ē	Cause (Disease or injury that initiated events c.													
Ж	resulting in death) L	Last	Due to	Due to (or as a consequence of):										
ca			d											
ed			1	_							- 1			
2	iF FEMALE: 23b. Was decedent			utcome of pregna		Testonia	nroanan	21/			23d. Date of delivery			
<u>cia</u>	in the past 12 1 ☐ Yes 2 ☐		4 ☐ Pre	birth 2 D Feta gnant at time of c		☐ Ectopic ☐ Other (s		-у				Month	n Day	Year
ys	9 Unknown		9 🗆 Unk	nown										
<u>-</u>	Part II. Other signif	ficant condit	ions contributing to	death but not res	ulting in the u	nderlying	cause giv	ven in Part	1.	23e. Did	tobacco	use contrib	ute to the ca	ause of death?
eted by Physician/Medical Examiner	Poor Nut:									1 🖸	Yes 2	2 □ No 3	☐ Probably	4 Unknown
										24a. Was		24b. We	re autopsy f	findings available
Compl			***							auto perf	opsy formed?	prid dea	ath?	tion of cause of
ပ္]Yes 2□	11/10			
Be	25. Was case referred to medical examiner? 1													
၉၂	1 Yes 2 📉		1 1	Inpatient 2	28b. Time o		OA L	4 U N		me 5 4 Res 28d. Describe			(Specify)	
ation	27. Manner of Deat 1 X Natural 2 ☐ Accident	5 🗌 Pendi		e of Injury nth, Day, Year)	Injury	М	28c. Inju Wo 1 🗆	rk?]Yes 2		zod. Describe	s How Inju	iry occurred		
Medical Certification: To	3 ☐ Suicide 4 ☐ Homicide	6	_: 20e, Plac	e of Injury - At he ding, etc. <i>(Specil</i>	ome, farm, str	eet, facto	ry, office			28f. Location City or To	(Street a own, Stat	ind Number te)	or Rural Ro	ute Number,
dical (29a. Certifier (Check only one)	1 Certifyi 2 Medica	ing Physician. To the I Examiner. On the and ma	e best of my kno basis of examina nner stated.	wledge, deat ation and/or ir	h occurre vestigatio	d at the t	ime, date a opinion, de	and place, eath occurr	and due to th red at the time	e cause(e, date ar	s) and mani nd place, an	ner as stated d due to the	d. cause(s)
Me	29b. Signature	tile of certific	ed	/		25	9c. Licen	se number			29d. D	ate signed (Month, Day,	Year)
		5	2 X				н163	96		:	Febr	ruary	27, 2	009
	Gerald M	ss of person	n who completed car , D.O. 27	W. 7th	n 23a) (Type, Street	Print) Fre	deri	ck, M	D 217	701				

State

Registrar

31. Date filed (Month, Day, Year)

300

parke

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 1 ^{Day} 25 **Physician** 2009 Jeannette Virginia Brannock 11:05 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Woods Center Cambridge Dorchester 8. Date of Birth (Month, Day, Year) Aug. 14, 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 7. Age (In yrs. last birthday Funeral Days Hours Months 1 M 2 X 1920 Director 219-03-4062 88 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County th and Mental Hygiene. ?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notifled at MD Dorchester Madison 1 ☐ Yes 2 X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 1218 Old Madison Road 21648 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status Black White etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or ite | ∏Yes 2 X No | Yes, Give | Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: white Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) autoclave technician hospital 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Brittingham Amy Wroten ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nettie Hastings niece P. O. Box 31, Ocean City, MD 21843 item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any Injury or conce. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2/28/09 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Mem. Park Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 5 Jem 700 Locust St., Cambridge, MD 21613 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** IVerticu lears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter order, mg Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) physician the burial Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl for use as t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Tyes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an ate has bage 2 s autopsy perform steoporosi certificate and 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation within 24 hours aner common to the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide t X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier eted cause of death (Item 23a) (Type, Print) Cambridge, MD 21613 ٥. 100 . Registrar's Signature State 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 2009 Tabaquero ebruar Bellows /Medical Arlene 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Plata If Under 24 Hrs ca If Under 1 Year 8. Date of Birth (Month, Day, Year) 1/01/1955 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min 1 □ M 2√2 F 53 1/01/ Director Philippines 578-25-4930 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County other traumatic event, the Medical Examiner must be notified at Director MD Charles 1XiYes 2∏No Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 1345 Wilson Road Funeral 20602 u.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimoré, Maryland 21215-0036 'natural", or 1 ☐ Yes 2√2 No Specify. þ 3 Widowed 4 □ Divorced Filipino Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. tem 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Disabled 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bacifico Tabaquero ္က Ambaro Estrada 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; If Item 27 is any injury or other trains 1345 Wilson Rd. Waldorf, Jackie Lou Mallari/Dtr MD. 20602 20b. Place of Disposition (Name of Riverdale Park 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/28/09 Riverdal<u>e Park, MD</u> Crematory 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Funeral Service Licens 2294 Old Washington Rd. Waldorf, MD. 20601 23a. art1. Enter the dividase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart the ure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death rho Physician disease or condition resulting in death) /Medical s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed SIS sician and burial-trans resulting in death) Last Due to (or as a consequence of) ending physician are use as the burial Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. been signed by the should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has e 2 s page certificate To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2XTNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this of funeral direction Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 29c. License number -26.2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month)

057

Registrar's Signature

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2/25/2009 0028 MICHAEL WAYNE BROWN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SUBURBAN HOSPITAL BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min **№** М 2 П F Yrs Director 57 5/2/1951 244-80-3625 Seaboard, NC Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the M. Shal Examinar in ust be inclined at 1 Yes 2 No Director Maryland Prince George's Clinton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5010 Plata Street 20735 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Tyes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify: Black þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Training Specialist Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Allen Brown Lillian Cloyd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print, 5010 Plata Street Clinton, Maryland 20735 Michelle R. Brown / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/28/2009 4 ☐ Donation 5 ☐ Other (Specify Clinton, Maryland Resurrection 21. Signature of Funeral Service Ligensee 22. Name and Address of FacilityPope Funeral Homes, P.A. 23a. Part 1 Effer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5538 Marlboro Pike Forestville, Maryland 20747 Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIAC ARREST /Medical Due to (or as a consequence of) Examiner RESPIRATORY FAILURE 1 WEEK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit PULMONARY INFILTRATES 2 WEEKS Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □No funeral director, page 2 should be detached 9 Dunknown 9 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC LYMPHOCYTIC LEUKEMIA 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2**∏** No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2NO No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 2 ☐ Accident 5 □ Pending 1 ☐Yes 2 ☐No investigation

or Attending Physician: The law requires that the death certificate be executed Box 68760. P.O. of Vital Records, **Division** death.

Maryland 21215-0036

Baltimore,

neral Director: A 24 hours a within 2 To the

Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6420 Rockledge Drive

6 ☐ Could not be

determined

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

Vinni Junja

29b. Signature and title of contifier

📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0066990

Bethesda, Maryland 20817

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2/25/2009

29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Year **Physician** 9:10 AMM Bennett Thomas Maurice February 27, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 11635 St. Andrews Circle Princess Somerset If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**№** M 2□ F 125-22-7027 Director 86 10-08-1922 New York Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Director Somerset <u>Princess Anne</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11635 St. Andrews Circle 21853 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. i filed within 72 hours after d I Hygiene. other than "natural", or iten 1 XYes 2 □ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Engineer</u> Chemical es 1 and 2 should be filed vof Health and Mental Hygie of Health and Mental Hygie If item 27 Is marked other i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maurice R. Bennett Beatrice Byrnes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen B. Bennett/wife 11635 St. Andrews Circle, Princess Anne, MD 21853 other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State SAlisbury Crematory | 02/27/2009 | 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, Maryland 22. Name and Address of Facility
Hinman Funeral Home 21. Si nature of Funeral Service Licens M00295 11673 Somerset Ave, Princess Anne, MD 21853 Jaa Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Hackinsons oars Asease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed and Due to (or as a consequence of): physician a Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached for 2 No Records, P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate 2 40 1□ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 110 Hospital: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After t or Attending 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 🗴 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of

20 I

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brett Hofmann, M.D.

MI

Que S. Salla

30434 Mt. Vernon Rd Princess Anne, MD 21853

2-27-09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1 - For State Registrar 08140 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3-7-2009 Pay Year 9:20 P M Muriel K. Baer 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Citizens Care & Rehab Center Frederick 8. Date of Birth (Month, Day, Year) 8-24-1912 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 1 □ M 2 🛛 F Days Hours Min 96 220-10-5054 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Frederick MD Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 USA 106 West College Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Medical Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edna E. Copeland Millard W. Hickman Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 16 Larch Ln Middletown, MD 21769 Judith Brandenburg Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 3-14-2009 Frederick, Maryland 4 □ Donation 5 □ Other (Specify) Mount Olivet Cem. 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Service Lice 106 East Church St. Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASC Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner ner

Physician

/Medical

Examiner

Funeral

Director

or than "natural", or Items 23a or 28a-f show

permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, If a M.

Baltimore, Maryland 21215-0036

68760.

Box

P.O.

Division of Vital Records,

Director

Funeral

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Completed

physician and the burial-transit Exami Physician/Medical aftending pl has been signed by the e 2 should be detached þ Completed page certificate Be Certification: To

The law requires that the death certificate be executed Physiclan: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, or Attending To the Hospital

State

Registrar

ical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

Dr. Austin Pearre MD 300 West 9th St. Frederick, MD 21701

RUTTR

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4 Homicide

(Check only one)

32. Registrar's Signature

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

00968

29d. Date signed (Month, Day, Year)

09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28a-1 per me, gas 9,03/13/09dhb

Reg. No.

Reg. No. 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** -EBRUARY Chong S. Chong 26,2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFORD DE HAVRE GRACE 1512ENS NURSING Homs If Under 1 Year | If Under 24 Hrs. Date of Birth 1/22/1930 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Age (In yrs. last birthday) Funeral Min. Months Korea 79 Days Hours 1 ☐ M 2 🛛 F Director 214-21-3792 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County · 28a-f show notified at 1 ☐ Yes 2X No Cecil Conowingo Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or the Medical Examiner must be 21918 1670 Liberty Grove Road Korea Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, tems 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 0, 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify Specify: Korean þ 3 Nidowed 4 Divorced 'natural' Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired)

Homemaker within 72 Elementary/Secondary (0-12) 12 College (1-4or 5+) than In home permit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important: If Item 27 Is marked other any Injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kyong Nung Choe Tok Won Pak 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Conowingo, MD 21918 1670 Liberty Grove Rd. Lisa Sjolie (Daughter) もME 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 3/2/2009 Burial 2 ☐ Cremation 3 ☐ Removal from State Whiteford, MD Mt. Vernon Meth. Ch. Cem. 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Tarring-Cargo Funeral Home, P. Aberdeen, Maryland 21001-3399 Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that reused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examinet burial-transit and Due to (or as a consequence of) ed by the attending physician detached for use as the buria Physician/Medical ルツ・ニョン・イスターコ・イスター J Division or Vital Records, P.O. Bbx 6 IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1□ Yes 2 1 No Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examiner Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) P 28a. Date of Injury (Month. Day Year) 27. Manut r of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 5 ☐ Pending investigation Injury + tural 01/09/2009 1 ☐ Yes 2 XNo Subject fell down stairs. Unknown[™] 2 Accident 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1670 Liberty Grove Road, Conowingo, MD 3 ☐ Suicide 4 ☐ Homicide determined Home t 🔽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Erup Gim

State Registrar

ESUP SIM 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

HONG, CHONG

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 28 Month **Physician** 2009 9:00 a Helen Fern Conard February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Union Hospital Elkton Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1□M 2☑F Months Days Hours 217-38-1608 68 VA Director January 14, 1941 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Cecil Elkton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with i Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 3 any injury or other traumatic event, the Medical Examiner must be n 2112 Old Field Point Rd. 21921 **USA** by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1□Yes 2□No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Medical 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ **Howard Ray** Ruby Dye 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2112 Old Field Point Rd., Elkton, MD 21921 Clayton T. Conard/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Elkton, MD Gilpin Manor Memorial Park March 3, 2009 22. Name and Address of Facility 21. Signature of Superal Service Licensee Andrew G. Gee Funeral Home, 259 E. Main St., Elkton. MD 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician days resulting in death) /Medical Due to (or as a consequence of) Examiner Preumoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) the 9□Unknown NIA 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 Yes 2 No 2 ☐ Accident after death in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D62190 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 BOW STREET SHAHNAWAZ KHAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 03 2009 Registrar

DHMH 17 Rev 1/2001

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		4	For State Registrar	State of Maryland /	Certificate of I			g. No.	
	01		1. Decedent's Name (First, Middle, Last)	\			2. Date of Death	Day Year	3. Time of Death
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1	Examin	er	4a. Facility Name (If not institution, give sti	, (4b. City, Town, of	Location of Death		4c. County of Deat	
	Funeral		5. Social Security Number 6. Sex	Ursing theme	pirthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		hplace (State or Foreign untry)
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	28e-	rect	My Somers 10e. Street and Number	E // //	10f. Zip Code	013	10	g. Citizen of What Co	untry?
	h with	al D	29760 Bryan	Hall Road	21	838		USA	
	r deal	Funeral Director	11. Marital Status	2. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	rs afte	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No	Specify:		Specify: Ri	ar K
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Heelth and Mental Hygiene. If item 27 ie marked other then "natural", or Iteme 23a or 28e-f show or other traumatic event, the Mudical Examiner must be notified at		15. Decedent's Education (Specify only highest grade		Sa. Decedent's Usual Occup (Give kind of work done)	ation	na 1	6b. Kind of Business/	Industry
215	within 7 ene. then *r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired	4)		2.11	Di L
	filed w Hygier other th		17. Fathers Name (First, Middle, Last)		Van Vrive	18. Mother's Name	(First, Middle, M	TOUITY	riani
Maryland	d be f	To Be	Robert Cor	hin		Clon	4 1 12	inne	
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-	and 2 selth a n 27 iv		Johnny S. Corbi	n (son) o	28905 Fair	nount ha	Mario	1 Station,	140 21838
ore	Pages 1 nent of He int: if iter iry or oth		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Re	come	of Disposition (Name of tery, crematory or other place	ce)	Date 2	toc. Location - City or	Town, State
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			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death. D	o not enter the mode of dyin	ng, such as cardiac o	or respiratory arre		Approximate Interval Between
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	= 000	/Me	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregnancy				23d. Date of del	iverv
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ta		0	25. Was case referred to medical			26. Place of Death			2□ No
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o uc	ing After une	ion:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28t	o. Time of 28c. Injury Wor	yat/ rk? Yes 2 □ No	28d. Describe how	w injury occurred	
Division	deat deat	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home,				eet and Number or Ru	ıral Route Number,
S	s after s after si Dire	Certification:	4 Homicide determined	building, etc. (Specify)			City or Town,	, State)	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		(Check only 2 Medical Examin	ician: To the best of my knowled er: On the basis of examination	dge, death occurred at the till and/or investigation, in my d	me, date and place,	and due to the ca	use(s) and manner as	stated. to the cause(s)
	thin 24	Medical	one) 29b. Signature and title of certifier	and manner stated.	29c. Licens			d. Date signed (Mont	
	0			OR USHANADSAN	21	1359		February:	,
	MAN		30. Name and address of person who cor	noleted cause of death (Item 23	a) /Type Print)	1 3 - 1		1	
	· ·		1415-5- DIVISION S	T, SHUSBURY	MD 21804.				
	Sta Regist		31. Date filed (Month, Day, Year) FEB 27 2009	7 , SALISBVRY 32. Registrar's Signature	harres				
			TLUG (/ (III)	morane in the					

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month Mary Crim 10:15 2009 March 4, 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Wicomico 6423 Hobbs Road Salisbury If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Months 1 □ M 2 💢 F 79 WEST VIRGINIA 236-44-4793 08/03/1929 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 📉 No MD WICOMICO SALISBURY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21804 USA 6423 HOBBS ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 💢 No
If Yes, Give
Year or Dates: Black. White, etc 1 X Never Married 2 ☐ Married WHITE 1 □Yes 2 No Specify. Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) MARTINSBURG MILLS Elementary/Secondary (0-12) College (1-4or 5+) CLERK OUTLET STORE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARY R. SHADE AARON M. CRIM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

TERRACE MADTINSRIEG WV 25401 19a. Informant's Name/Relationship (Type. Print) 502 EDGEMONT TERRACE, MARTINSBURG, WV ROBERT A. CRIM/BROTHER MARCH Date 20b. Place of Disposition (Name of FACETING WATERS PRESS).
CHURCH CEMETERY 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State HEDGESVILLE, WV 9, 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, 21. Signature of Funeral Service Licensee 327 W. KING ST., MARTINSBURG, WV 25402 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final evalom disease or condition resulting in death) Due to (or as a consequance n) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 NO 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner Examine Hospital or Attending Physician: The law requires that the death certificate be executed hours after death.

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

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Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mcdical Evantural two notified 21

filed within 72 hours after death I Hygiene.

s 1 and 2 should be fif f Health and Mental be tem 27 is marked ot

permit. Pages 1 a
Department of He
Important: If item
any Injury or oth

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

been signed by the attending physician and should be detached for use as the burial-trar Physician/Medical þ Completed within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s Be Certification: To

Medical

29a. Certifier

25.	Was case referred to medical examiner? 1 Yes 2 No
27.	Manner of Death

Natural 5 ☐ Pending investigation ∠ Accident 6 ☐ Could not be 3 🗌 Suicide determined 4 Homicide

28a. Date of Injury (Month, Day, Year)

28c. Injury at Work? 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the companion.

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

and manner state Signature and title of certific

29c. License number

nation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

acs

32. Registrar's Signatur

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 9

Certificate of Death Reg. No.

			For State Registrar	oldio ol illo	,	Certificat			Re	eg. No.	009	00140
	Physicia	an	1. Decedent's Name (First, Middle, La		•	-			2. Date of Deat Month	Day	Year	3. Time of Death
	/Medic	al	Floyd. 4a. Facility Name (If not institution, given	Richar	'd		ender		March	8,	2009	11:40 P M
	Examin	er	Julia Manor Healt		iter	1	ersto	Location of Death			nty of Death hingto	n
	Funeral Director		Social Security Number 6. S		e (In yrs. last birti			If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 9,	Year)	9. Birthp	lace (State or Foreign
	pu »		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Logotian						Od. Inside City Limits
	faryla Fshov	ō									1	1 ∐Yes 2 🛣 No
	the N	rect	MD Washing	gron	надет	stown 10f. Zip	Code		1	0g. Citizen	of What Coun	try?
	3a or	Funeral Director	17620 W. Washing	ton St.		2	21740)			U.S.A.	
	deatl	ner	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.			spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-	14, [Race - Americ Black, White, e	
215-0036	be filed within 72 hours after death with the Maryland Hygiene. ad other than "natural", or items 23a or 28a-f show event, The Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🔯 Widowed 4 ☐ Divorced	1 Mayes 2 N If Yes, Give Year or Dates:	10	1 □Yes			Thours, Oto.y		ecify:	ite
ק	72 hc "natu dical	Completed	15. Decedent's En (Specify only highest gra	lucation ade completed)	16a.	Decedent's Usu (Give kind of wo	rk done o	luring most of work	ing	16b. Kind o	f Business/Ind	dustry
7	s filed within 72 h Il Hygiene. other than "nati rent, In. Medic	dmo	Elementary/Secondary (0-12)	College (1-4or 5-		iife. DO NOT u ssemble:)		irers	ft Man	ufacturing
2	filed Hygin	Be Co	17. Father's Name (First, Middle, Last)		OGCIND IC.		18. Mother's Name				diacturing
yland	ild be fental rked o	To B	Charles Elmer Cav	ender				Bertha M	lessersmi	th		
Mary	2 should be and Mental is marked araumatic ev		19a. Informant's Name/Relationship (Турв. Print)	19b.	Mailing Address	(Street a	and Number or Rui	al Route Number	City or To	wn, State, Zip	Code)
Ξ.	and 2 ealth n 27 i		Connie D. Cavende	r/Daughter				ington St				21740
aitimore,	ges1 tofH Miter		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	20b. Place of cemetery	Disposition (Nar y, crematory or c	ne of ther plac	θ)	Date 2	20c. Location	on - City or To	wn, State
	t. Pag timen tant: tant:		4 ☐ Donation 5 ☐ Other (Special	<i>(y)</i>	Rest H	aven Ce	mete	ry 3/12/	2009 1	lagers	stown,	MD
a D	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ed once.		21. Signature of Funeral Service Lice	isee				s of Facility Res				
			23a. Part 1. Enter the disease, or com	plications that caused	the death. Do n			ylvania <i>A</i> g. such as cardiac			own, ML	21742 Approximate Interval Between
	Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	aD_	a consequence o	es est,	M	e H.tv	ζ			Onset and Death
'n	certificate be executed ding physician and ise as the burial-transit	Examiner	Sequentially list conditions, it are the original to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence o	·						
09/8q	ate be nysicii he bu	Medical		" d								
O. Box 68	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending placemental prector. After this completely filled in by the funeral director, page 2 should be detached for use as to	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 ☐ Ectopic p 5 ☐ Other (sp		1		23d.	Date of delive	ery Day Year
Ţ.	that hed by detail		Part II. Other significant conditions	ontributing to death bu	ut not resulting in	the underlying o	ause give	en in Part I.	23e. Did tob	acco use c	ontribute to th	e cause of death?
Vital Records,	quires n sign	d by							1 □ Ye	s 2 🗆 N	o 3□ Prob	ably 42 Unknown
ပ္တ	aw rec	Completed							24a. Was ar	n 24	b. Were auto	psy findings available
ř	The late has	mo;							autops perforn 1 □ Yes 2	ned?	death?	npletion of cause of
<u> </u>	clan: ertific ctor, I	Be C	25. Was case referred to medical examiner?					26. Place of Deat	h (Check only one	e)		
010	hysic this c		1 Yes 2 10 10	and the same of th	nt 2 ER/Out		Othe	er: 4 Nursing Ho				()
ב	ding F	ion:	27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Injur (Month, Day	ry 28b. T <i>y, Year)</i> In	ime of 2 jury M	28c. Injury Work		28d. Describe ho	w injury oc	curred	
DIVISION	or Attencatter death Director:	Certification: To	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 290 Place of Inju	ury - At home, far c. <i>(Specify)</i>			∕es 2□No	28f. Location (Sti City or Town		ımber or Rura	l Route Number,
_	e Hospita 124 hours e Funeral letely fillec	Medical Co	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	nysician: To the best on miner: On the basis of and manner sta	examination and	death occurred for investigation	at the tin	ne, date and place, pinion, death occur	and due to the cared at the time, da	ause(s) and ate and plac	I manner as s ce, and due to	tated. the cause(s)
•	To th withir To th comp	Me	29b. Signature and title of certifier	holm				6039	6	031	gned (Month,	Day, Year)
			30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, Print)	112	1 of	ale	-t m	9 31	740
	Sta		31. Date filed (Month, Day, Year)		ar's Signature	1	,	11. A				

DHMH 17 Rev 1/2001

241

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08147 State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month Year **Physician** 4:00 P M Krystyna Cichocki March 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 7426 Skyline Drive Frederick Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 📆 F Yrs. **Director** 154-28-8556 88 6-11-1920 Poland Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, to the died Evander must be mained at 1 ☐ Yes 2 No Director MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7426 Skyline Drive 21702 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 \end{array}$ College (1-4or 5+) Lab Technician Electronics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wladyslaw Swiecka Maria Menda 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 i Jolanta Vaughan Daughter 7426 Skyline Drive Frederick Maryland 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages 1
Department of F
Important: If ite
any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PeterChurch Cem. 3-12-2009 Libertown, Maryland 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Service Licensee M01176 106 East Church St. Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive /Medical Due to (or as a co uence of) Examiner Sequentially list conditions, if any, leading to immediate outset. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 XNo Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1 TYes the Hospital or Attending Physician: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated within 2 To the I 29b. Signature ttle of certifier 29c. License number 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) ohnson Dr Frederick, MD 21702 Ihomas 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

MAR 1 6 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** February 2009 8:45a Virginia L. Dankmeyer 28, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick 1421 Taney Avenue Frederick # 320 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🖾 F Yrs. July 5, 1931 Director 216-28-8397 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, I'm Madical Event is at 1 unst be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director Maryland Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States # 320 1421 Taney Avenue <u> 21702</u> Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify. Specify. ģ 3 ™ Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ William Shreck Alice Wise 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Norma Draper/ Daughter 3597 Fremont Court, Ijamsville, Maryland 21754 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State Stauffer Crematory Inc 3/2/2009 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility stauffer Funeral 621 Opossumtown Homes Pike, P. A. Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that eaused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cancer Physician -undisease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if eny, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Was autopsy performed? has page 2 After this certificate 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 5 Pending 1 Natural 1 □Yes 2 □ No ours after death.

leral Director: A
filled in by the fu 2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/200

State

29b. Signature and title of certifier

31. Date filed (Month

MYN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pe crup

Registrar's Signature

050603

ney Ave Frederick, M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	ii yiaii	•	rtificate of l			eg. No.	1000	08149
	Physicia	an	1. Decedent's Name (First, Middle, Last)						2. Date of Deat Month		, 2009	3. Time of Death 8:05 A M
	/Medic Examin	al	Anna Margaret Dr 4a. Facility Name (If not institution, give s				4b. City, Town, or	Location of Death	February		County of Death	0:03 A ···
	Examin	CI	Tate Hospice House			_	Linthicu				ne Aruno	
	Funeral Director		082-22-9707	7. Age	(In yrs. I	(ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sept 27	Yea <i>r</i>)	.928 Cont	place (State or Foreign ntry) necticut
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Limits
	e Mary Ba-f sh	ctor	MD Prince Ge	orge's	Laur	el						1 □Yes 2 X No
	ith the	Funeral Director	10e. Street and Number	. // 0 ^			10f. Zip Code 20708			0g. Citi JSA	izen of What Cou	ntry?
	ns 23	eral	11706 S. Laurel Dr	12. Was Decedent E	ver in U.	S. 13. \	Was Decement of H	ispanic Origin? (Sp			14. Race - Ameri	can Indian,
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or items 23a or 28a-f show amy highty or other traumatic event, I'm Medical Examinat rout be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Forces? 1	lo	1	lf Yes, specify Cuba 1 □ Yes 2ሺ No	n, Mexican, Puerto	Rican, etc.)		Black, White, Specify: Wh:	
5-0	72 ho 'natur	eted	15. Decedent's Educ (Specify only highest grade	cation e completed)		16a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work	king	16b. Ki	nd of Business/Ir	ndustry
121	within ene. than than	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Homema		")		Own	i Home	
<u>ام</u>	I be filed wantal Hygie ed other test other	Be C	17. Father's Name (First, Middle, Last)			, roman		18. Mother's Nam	e (First, Middle, I			
ylar	should be and Menta s marked	70	Joseph Paul Bolek					Mary Kop				
Mar	d 2 sho th and 7 is m traum		19a. Informant's Name/Relationship (Ty	pe. Print)		1	ng Address (Street					p Code)
ē,	t and a f Health tem 27 i		John F. Drago/son 20a. Method of Disposition		20b. F	46 Cr	rescent Rosition (Name of matory or other place	d. #E Gre	enbelt, Date		20770 ocation - City or To	own, State
<u>E</u>	Pages nent of I ant; If ite ury or o		1 ☐ Burial 2 【A Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)				1 Cremat		8/09	Oden	ton, MD	
Baltimore,	permit. Page Department (Important; If any Injury or once.		21. Signature of Funeral Service License	He Otto	MO1	251 Be	Name and Addre	ss of Facility Crematic	n Servi	ce Cla	P.O. Box	x 784 - MD 21029
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	cations that caused ne cause on each lin	the deatl	h. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arr	rest,	ITVO VITI	Approximate Interval Between Onset and Death
5	Physician		Immediate Cause (Final disease or condition resulting in death)	. Metastat			rcinoma	of Lung				6 months
	/Medical Examiner			Due to (or as a	a conseq	uence of):						
	₽ #	ner	Sequentially list conditions, if any, leading to immodate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consid	uence of):						
	tificate be executed ig physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	concen	uance of):						
68760,	sician burial			Due to (or as a	a corrseq	dence oi).						
687	= 0, 6	Medical		J	-							
O. Box	ath cer attendir or use	Physician/N	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 🗌 Feta	death 3	☐ Ectopic pregnand ☐ Other (specify) _	у			23d. Date of deliv Month	very Day Year
s, P.	w requires that the de s been signed by the s should be detached f	þ	Part II. Other significant conditions con	ntributing to death bu	ut not res	ulting in the u	nderlying cause giv	en in Part I.				the cause of death? bably 4 📉 Unknown
Vital Record	The law rec cate has bee page 2 shou	Completed							24a. Was a autops perform		prior to co	opsy findings available ompletion of cause of 2 □No
/ital	ician; Th certificate ector, pag	Be C	25. Was case referred to medical examiner?				Lou		th (Check only or	ne)		
of/	ding Physician: h. After this certific funeral director,		1 ☐ Yes 2 X No 27. Manner of Death	Hospital: 1 ☐ Inpatie 28a. Date of Injul		ER/Outpatie	nt 3 DOA Oth	4 LI Nursing n	ome 5 Residence			ify) hospice
on	th. : After e funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day	y, Year)	Injury	Wor	k? Yes 2 □No	234, 5000115011	o, o .	, 55541154	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification: To	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ury - At ho c. (Specia	ome, farm, str fy)	reet, factory, office		28f. Location (S City or Tow			ral Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (rsician: To the best of iner: On the basis of and manner sta	f examina							
	To the within To the comp	Me	29b. Signature and title of certifier		,	. \	29c. Licens				te signed (Month	
	\bigcirc		1/ (1 Kepta)	701	M	0	D087	54	I	Febr	uary 27	, 2009
	(S) p		30. Name and address of person who are thomas A. Bensinge	Impleted cause of deer, M.D. 7	eath (Iter 7525	n 23a) (Type, Green v	vay Cente	r Drive S	Suite 205	5 Gr	eenbelt,	, MD 20770
	Sta Registi		31. Date filed (Month, Day, Year) MAR 03 20	32. Begistra		ature.	harred	-10				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Ma	ryiand / L	epartment Certificate	of H	eaith and r Death	vientai Hyg	giene Reg. No.	2009	08150
	Physicia	an	1. Decedent's Name (First, Middle, Last Vincent F. DiP						2. Date of Dea		28 2009	3. Time of Death
7.	/Medic	al	4a. Facility Name (If not institution, give			4h. City. Tr	own. or	Location of Death			County of Death	
; 	Examin	er	Carroll Hospital			1		ninster			Carrol	
_	Funeral		Social Security Number 6. S	ex 7. Age	(In yrs. last birt	i Months I	Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da NOV 0	L h v. Ye <i>ar)</i>	9. Birth	place (State or Foreign intry)
Ε.	Director		214-16-8191	⊠ M 2□F	87	frs.			Nov 0	1 19	21	MD
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	Mary F sh	tor	MD Carr	oll		Finksbur	g					1 □Yes 2 🛣 No
	or 28	Director	10e. Street and Number			10f. Zip C				10g. Citi	zen of What Cou	intry?
	23a	ral	2019 Arabian Dri					048			USA	
	er de	Funeral	11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent Ev Armed Forces? 1X\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	1040	13. Was Decede If Yes, specif	ent of Hi fy Cuba	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)		 Race - Amer Black, White, 	
920	urs aff	2	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1946	1 □ Yes 2	∑ No	Specify:			Specify: Wh	ite
2	72 hor	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a.	Decedent's Usual (Give kind of work	Occupa	ation Juring most of work	kina	16b. Ki	nd of Business/I	ndustry
2	vithin ne.	mp	Elementary/Secondary (0-12)	College (1-4or 5+	,	`life.' DO NOT use Baltimore	retired)		Mar	ine Div	ision
, D	iled w Hygie ther t		12 17. Father's Name (First, Middle, Last)			ратсшоге	e C.	18. Mother's Nam				121011
an	ld be l ental ked o ic eve	To Be	Joseph DiPietro					Frances	Sortin	0		
ary	1 and 2 should be filed within 72 hours after death with the Maryland Heath and Mental Hygiene. Heath and Mental Hygiene. and 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm Medical Exercites must be notified at	-	19a. Informant's Name/Relationship (Type. Print)	I	Mailing Address (
Σ	and 2 ealth a n 27 b		Margarita DiPiet	ro/wife		2019 Aral						
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If team 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐	Removal from State		Disposition (Name y, crematory or oth			Per 2009		cation - City or T	
Ë	it. Pae rtmen rtant: njury		4 ☐ Donation 5 ☐ Other (Specif	v)	Garri	son Fore		<u>'</u>			ngs Mil	ls, MD
Ba	perm Depa Impo any i		21. Sa ature of Funeral Service Acer	See				erai Home				21157
			23a. Part 1 Enter the disease, or corn shock, or heart failure. List only	oncations that caused t	he death. Do r						C3. 7 11D	Approximate Interval Between
3	Physician		Immediate Cause (Final	one cause on each line	flere	seles	> 5 10	1				Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a								y / 3
	Examiner	L	Sequentially list conditions.	b								
	red Isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence o	of):						
	execui n and al-trar	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	consequence	of):						
68760,	tificate be executed g physician and as the burial-transit	edical		d								
68	rtificat ng phy as th	/ledi	IF FEMALE:	-							ı	
Вох	eath cer attendir for use	lan/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	Fetal death			<i>y</i>		1	23d. Date of deli	very Day Year
P.O.	he dei the a	Physician/M	1 ☐Yes 2 ☐No 9 ☐Unknown	4 ☐ Pregnant at 9 ☐ Unknown	ime of death	5 ☐ Other (spe	ecify)					
σ.	ires that the de signed by the a I be detached t		Part II. Other significant conditions of	ontributing to death but	not resulting in	the underlying car	use give	en in Part I.	23e. Did to	obacco u	ise contribute to	the cause of death?
Division of Vital Records,	quires n sigr uld be	d by							1 🗆 ١	'es 2[□ No 3□ Pro	bably 4 nknown
000	aw rec is bee 2 shou	plete							24a. Was		24b. Were aut	opsy findings available ompletion of cause of
<u> </u>	The late has page	Completed							autop perfo 1 □Yes	rmed?	death?	2 No
/ita	clan: ertific	Be (25. Was case referred to medical examiner?	I I a series in the series in		-=	Loui	26. Place of Dea	th (Check only o	ne)		
of \	Physi this c		1 Yes 2 ♣No 27, Manner of Death	Hospital: 1 Impatier 28a. Date of Injury		tpatient 3 DOA	A Other	4 Li Nuising n	ome 5 Resid			ify)
o	ding h. After funer	tion	1 ■ Natural 5 ■ Pending 2 ■ Accident investigation	(Month, Day,		njury M	Work	yes (? Yes 2 □ No	200. Describe i	iow injui	y occurred	
/isi	Atten r deat ector: by the	ifica	3 Suicide 6 Could not b		y - At home, far	rm, street, factory,			28f. Location (S			ral Route Number,
á	tal or s afte al Dir ed in	Certification: To	4 D Hollicide	building, etc.	(Specify)				City of Tov	m, otate	,	
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use.	Medical		nysician: To the best o miner: On the basis of and manner stat	examination an							
	Fo the within Fo the Somple	Me	29b. Signature and title of certifier					e number			te signed (Month	
	WJL		Mond	7. M.	, ,	20	0	3288	2	0	3/01/0	99
9	3+1 JA		30. Name and address of person who	completed cause of de	ath (Item 23a)	Type, Print)		esul.	11- K	2.6.	L for.	99 , Ml 21136
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	's Signature							21106
	Registi		MAR 0 2	2009 Jenes	u S.	parke	1					
DUA	JH 17 Rev 1/2	001		*		18						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 🖯 🛭 🗎 1 - For State Ragistrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 815 P E DWARD ANNY DORAN 03 06 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Koad 8016 LONG PASA DENA Anne Rundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 216-14-4767 -14-22 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or 28a-f show 1 ☐ Yes 2 No PASADENA Completed by Funeral Director ANNE ARUNDE 10f. Zip Code 10g. Citizen of What Country? 8016 LONG HI 21122 Items 23a Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nnt: If item 27 Is marked other then "naturel", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 42-43 Specify: Specify: WhITE 3 Widowed 4 Divorced treumetic event, I're Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ILBERT B. MAGDELINE HEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8016 LONGHILL RD. PASADENA Department of Health a Importent: If item 27 Is eny injury or other tree once. INA L. DORAN, WIFE MD. Z1122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 3-11-09 CROWNSVITE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Pacility DAURHERTY KNERAL HOME 2601 MOUNTAINED. MASADENA, MD. 2112Z 23a. Part1. Enter the disease of complications that valued the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death a Dysphasia with Chronic Immediate Cause (Final Aspiration Cheumonia Priysician disease or condition resulting in death) /Medical Examiner ardiovascula Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Pulmon any Disease hronic Obstructive Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Ď 912heimer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed betes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an CORNARY AFTERY Attial Disease Fibrillation 2 No Division of Vital 1 Tes Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑No 2 ER/Outpatient 3 DOA 27. Manner of Death 1 ☑ Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation death. 1 Yes 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel I 29a. Certifier 🖎 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 0 CRNP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3900 Loch RAVER BLUD # 2 Baltimore MD 21218 Sheena IPStrudwick 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:20a M 2009 Adolph Evans March /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Brinton Woods Nursing&Rehabilitation Sykesville Howard Birthplace (State or Foreign Country) Year If Under 24 Hrs. Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Funeral Months Days 157 M 2 □ F 217-01-8798 93 Director 12/11/1915 W. Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 KNo Md. Howard Ellicott City Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 11983 Frederick Road 21042 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 10/10 14. Race - American Indian. 11. Marital Status 1 Green Porces? 1940— If Yes 2 No 1945 Pear or Dates: 1945 Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2X No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Superintendent U.S. Postal System 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Evans Anna Kanchaus ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11983 Frederick Road Ellicott City, Md. 21042 Grace Scales Evans/wife 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burjak 2 Cremation Removal from State 4 □ Donation 5 □ Other (Specify) Ardent Crematory Inc. 3/3/2009 Hanover, Md. 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signature of MO0845 4112 Old Columbia Pike Ellicott City, Md. 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each light. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2€No 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred e Hospital or Attending P 24 hours after death. e Funeral Director: After t letely filled in by the funera Certification: Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and fittle of certifie 29c. License number 70806 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mens WO 54/20 102 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 3 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Dolores Elder February 2009 7:15A Mary 24. /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cîty, Town, or Location of Death 4c. County of Death Examiner 9876 Charles Street La Plata Charles If Under 1 Year | If Under 24 Hrs. | Months | Davs | Hours | Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
New York Funeral Months 1 □ M 2 □XF Director 079-20-6821 March 11,1927 Usual Residence of Decedent permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Martical Exercises must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Charles | La Plata 1X Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 9876 Charles Street 20646 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. þ Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James J. Carr Mary J. Keeler ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Beth Dean/Daughter 8960 Dove Drive, Bel Alton, MD 20611 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart Cemetery 3/2/2009 4 ☐ Donation 5 ☐ Other (Specify) La Plata, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
AREHART-ECHOLS FUNERAL HOME, P.A. M00945 www. 211 St. Mary's Ave. La Plata,MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MINTERSTITED /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, been signed by the attending physiclan should be detached for use as the burla Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) □Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably W Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an s certificate has lirector, page 2 s autopsy performed? Yes 2X No 1 Tyes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Hospital Other: 4 Nursing Home St Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day/ Year) 23a) (Type, Print) address of berson who completed cause of Hen 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State FEB 27 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month March 1, 2009 10:10 A Forest R. Garv 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Ft. Washington Prince George's Ft. Washington Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV 11, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1**XX**M 2□ F 1945 63 Washington, DC 215-44-4723 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h. County Forest Heights Prince George's 1 ☐ Yes 2 No Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20745 5506 Woodland Drive 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 106 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1965-1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married White 1 ☐ Yes 2XXNo Specify. Specify: 1971 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Verizon Technical Support 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Evelvn Haney Forest 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24801 Beauchamp Branch Road Denton, Maryland Bertha Pippin / Aunt 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 03/07/2009 Ft. Lincoln Cemetery Brentwood, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signatur of Fun Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland win Liver 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): = PS1 Sequentially list conditions, if any, leading to inninediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performer res 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one,

Physician /Medical Examiner

death certificate be executed

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Vital Records.

Division or

Physician:

Physician

/Medical

Examiner

10a. State

Director

Be Completed by Funeral

2

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

e filed within 7. al Hygiene.

Department of Health and Department of Health and Important: If them 27 is mis any injury or other 2000ce.

should be Mental is marked

Maryland

3altimore,

72 hours after death with the Maryland

Physician/Medical Examiner as Be Completed by Certification: To

the burial-tran attending physician ed by the a detached f cate has been signed page 2 should be del certificate has been funeral director, ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director; After the letely filled in by the funeral

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

1 Yes 2 No

27. Manner of Death

2 Accident

3 ☐ Sulcide

4 Homicide

atural

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA 28d. Describe how injury occurred

Hospital: 28a. 5 Pending investigation

Date of Injury (Month, Day Year) 6 Could not be determined

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of dertifie

30. Name and address of person to dompleted cause of death (Item 23a) (Type, Print)
Samuel Kleiman MD 11711 Livingston Road Ft. Washington, Maryland Samuel Kleiman MD 31. Date filed (Month, Day, Year)

32. Registrar's Signatu MAR 0 3 2009

and manner stated.

Medical

To the Hosp within 24 hou To the Fune completely fi

1V0-

09-01684 Brian Ford Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 26, 2009 1845 hrs **Medical Examiner** Brian Ford 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Somerset Princess Anne 11635 Beechwood Street Apt. C Date of Birth (MM/DD/YYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Country) Mary land Months Days Hours Min Director 09/05/1964 44 1 M 2 F 215-90-0909 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 1 X Yes 2 No Princess Anne MD Somerset 28a-f show notified at once. death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 11635 Beechwood Street 21853 USA 23а (Funeral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Yes White Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiène. ant: If item 27 is marked other than "natural", on or other traumatic event, the <u>Medical Examiner m</u> Yes 2 No specify: Specify Give Yea Divorced Widowed 4 à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Waterman Seafood 10 none 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Glenwood Ford Barbara Mae Catlin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print.) 9607 Old Princess Anne Road, Westover, MD 21871 Mary Catlin/Aunt 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Removal from State Burial 2 X Cremation 3 tant: Salisbury Crematory 03/06/2009 Salisbury, Maryland Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home 17 M00295 11673 Somerset Ave. Princes Anne reaused the death. Do not enter the mode of dying, such as cardiac or re-piratory arrest, shock, or near pproximate nterval Between Onset and art I. Enter the disease, Physician or complications to failure. List only one cause on each line /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease) xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed AMENDED 23a,27, perME, g889 3/17/09 TT Physician/Medical X UNPENDED attending physician a Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live birth Month Fetal death past 12 months' Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed? death? Yes 2 ✓ Yes to Hospital or Attending Physician; Ti n 24 hours after death. The Funeral Director: After this certifica letely filled in by the funeral director, pa 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other₄ Hospital: Nursing Home 5 Residence 6 V Other: Scene DOA Inpatient 2 ER/Outpatient 3 1 🗸 Yes 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 1 X Natural Pending Yes 2 No 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier February 27, 2009 , M.D O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ling Li, MD egistrar's Signatur 31. Date filed (Month State Registrar

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, The Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending aboverned on the second or the se To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

Robert L.

31. Date filed (Month, Pay, Year

	1 - For State Registrar			Cer	tifica	te of L	Death			Reg. N	.20	09	08	156
an	1. Decedent's Name (First, Middle, Las	(t)							2. Date of De Month	D.	ay	Year	3. Time of	
al			A. Gi	lbert_	41- 0:1-	Town	Landing	of Dooth	Februa			2009	12:00a	a
er	4a. Facility Name (If not institution, give		er)		4b. City	y, Town, or		_		40		of Death	J . 1.	
-	Citizens Nursing 5. Social Security Number 6. S		Age (In yrs. la	ast birthday)		er 1 Year	deri If Under	24 Hrs.	8. Date of Bir	th Variation		reder 9. Birthp	lace (State of	Foreign
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Completed by Funeral Director	15. Decedent's Ed			16a. Deced	ient's Us	ual Occupa	ation	t of work	ina	16b.	Kind of B	usiness/Ind	dustry	
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	19a. Informant's Name/Relationship (-	•			al Route Numb field,)
	Donna Hering/ Dau 20a. Method of Disposition	gnter	20b. Pl	ace of Dispo	sition (Na	ame of	1		Date		<u> </u>	- City or To		
	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		ite	emetery, cren			i .	3/3/	2009	E'm	o d o m d	fold 1	Marzzla:	nd
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ian/	23b. Was decedent pregnant in the past 12 months?		th 2 🗍 Fetal	death 3		pregnancy	y					ate of delive onth		ear
ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnar 9 ☐ Unknow	nt at time of d n	eath 5L	Other (specity)								
Completed by Physician/I	Part II. Other significant conditions of	ontributing to deat	h but not resu	Ilting in the ur	nderlying	cause give	en in Part I	l.	23e. Did t	obacco	use con	tribute to th	ne cause of de	eath?
d b	Demen	two							10	Yes 2	2 No	3☐ Prob	ably 4 □ U	nknown
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Be C	25. Was case referred to medical						26. Place	e of Deat	th (Check only o	/		10163	2/3/10	
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on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of (Month,	Injury <i>Day, Year)</i>	28b. Time of Injury		28c. Injury Work			28d. Describe	how inj	ury occur	red		
cati	2 Accident investigation 3 Suicide 6 Could not b		1.5		M		Yes 2□	JNo	005 1"	04-		t	1.0	
il il	4 Homicide determined	28e. Place of	Injury - At ho , etc. <i>(Specit</i>)	me, tarm, str /)	eet, facto	ory, office			28f. Location (. City or To	street a vn, Sta	and Numl te)	per or Rura	ii Houte Numi	per,
ဦ	29a. Certifler 1 Certifying Pt	nysician: To the be	est of my kno	wledge, deat	h occurre	ed at the fir	ne, date a	ind place	and due to the	cause	(s) and m	nanner as s	stated.	
Medical Certification: To		niner: On the basi and manner	is of examina											
Ze	29b. Signature and title of certifier				2	9c. License	e number			29d. D	ate signe	ed (Month,	Day, Year)	

Kaufmann MD 300 West 7th Street, Frederick, Maryland 21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 7:30 PM 2009 25 February GORDON RACHEL DELORES /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George Hyattsville Sacred Heart Nursing If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5 Social Security Number **Funeral** Days Hours Min. 1 □ M 2 T F 87 yrs. North Carolina 2/14/1922 Director 579 40 3542 Usual Residence of Decedent ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Hyattsville Prince George 1 ☐Yes 2 ☐ No Md Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20782 5805 Queens Chapel Road U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 K No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Specify: Black 1 ☐ Yes 2 ☑ No Saltimore. Maryland 21215-0036 Specify Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Food Handler 12th18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Maude Waters

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 0 7 7 2 Hopkins <u>Robert</u> 19a. Informant's Name/Relationship (Type. Print) Choice Rd, 14629 Colonels Upper Marlboro Md Diane P. Ables, cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 20a. Method of Disposition permit. Pages 1 Department of H Important: If iter any Injury or oth 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 3/5/09 Brentwood, Md Fort Lincoln 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hall Brothers Funeral Home Puneral Se vice License 0333 621 Florida Avenue, NW, Washington DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final in the liver of unknown Malignara Physician unknow 1 disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner that the death certificate be executed burial-tra Due to (or as a consequence of): physician s the burial Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Dav 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the detached 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ģ 4 Unknown 2 No 3 Probably 1 ☐ Yes Completed neec 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy perform page certificate Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one funeral director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Z No 2 ER/Outpatient 3 DOA 1 Inpatient 2 After this 27. Manner of beath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: ...al or At...
ours after deati...
al Director: Ati.
in by the fur 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D 🔾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cenffier

Registrar

State

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Rive; Buntonsvil

cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February ^{Day} 26 **Physician** 2009 Carl LeRoy Haglund 9:40 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Chesapeake Woods Center Cambridge Dorchester | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 3, 1929 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Months 1 DM 2 □ F 79 217–30–8890 Wisconsin Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD Dorchester Cambridge 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 525 Glenburn Avenue 21613 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 DXYes 2 □ No Maryland 21215-0036 1 □Yes 2 🛂 No If Yes, Give Year or Dates:1947–50 Specify. Specify: white þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the IMS Elementary/Secondary (0-12) College (1-4or 5+) owner building contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gustav Helmer Haglund Bergljoth Toraasen ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Willey niece P. O. Box 190, Bethel, DE 19931 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Salisbury Crematory 2/27/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Immediate Cause (Final **Physician** neumoma upoks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner phagin Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical the as attending IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performe certificate 1 ☐ Yes 2 No 2 🗆 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this of funeral din 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie se of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Funeral

28a-f show

23a or

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2009 **Physician** Frederick Hodgdon, Jr Feb 26. 6:05 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Bradford Oaks Nursing Home Clinton Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea, Nov 26, 1 Birthplace (State or Foreign Country) Months Days Hours Min. 323 12 0781 1 M 2 □ F Nov 1916 Chicago, 92 I11 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD P.G. UPPER MARLBORO 1 Yes XXNo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? MATTAPONI ROAD 20772 11243 UNITED STATES Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. Specify: White 16b. Kind of Business/Industry Advertising/Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11243 MATTAPONI ROAD, UPPER MARLBORO, MD 20772 20c. Location - City or Town, State CLINTON, MARYLAND 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, CLinton, MD 20735 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009

		For State Registrar		Certi	ficate of D	eath	F	Reg. No. 20	09 08160
		1. Decedent's Name (First, Middle, Last)	7.4			Date of Dea Month		3. Time of Death
Physici /Medio		ANTHONY LATRELL F	IENSON					/2009	12:28 p M
Examir		4a. Facility Name (If not institution, give	street and number)	4	b. City, Town, or L	ocation of Death		4c. County o	
- O		SOUTHERN MARYLAND			CLINTON	If Under 24 Hrs.	To D		GEORGES
Funeral		5. Social Security Number 6. Se	TMM 2 D F		f Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Da	y, Year)	Birthplace (State or Foreign Country)
Director		579-94-0586 Usual Residence of Decedent	33				3/5/19	/5	Cheverly, Maryla
land ow		10a. State 10b. County	10c. City, T	Town or Locat	ion				10d. Inside City Limits
Mary -f sh	ţō	Maryland Prince ge	orge's Can	itol H	eiohts				ty⊈Yes 2 □ No
r 28a	irec	10e. Street and Number	orge 3 oup.	1001 11	10f. Zip Code			10g. Citizen of WI	hat Country?
3a o	a D	7311 Shady Glen Te	errace		20743		1	United S	tates
-UU36 hours after death with the Maryland tural", or items 23a or 28a-f show all Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Wa	s Decedent of His	panic Origin? (Sp . Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race	- American Indian, , White, etc.
after of its	F	1 □Never Married 2 □ Married	1 □Yes 2√⊋ No			Specify:			Black
5-0036 72 hours aff natural", or	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:				-		
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within iene.	d m	Elementary/Secondary (0-12)	College (1-4or 5+)					Country	C
2 0 0 T	ပိ	12 17. Father's Name (First, Middle, Last)		Bullal	ng Engine		e (First, Middle,	Maiden Surname	Government
	Be C		Ulikilowii			Gertrude	Henson		
IOTE, Maryland ges 1 and 2 should be file tr of Health and Mental H, tr item 27 is marked oth or other traumatic event	မ	19a, Informant's Name/Relationship (7	ype. Print)	19b. Mailing	Address (Street ar			er, City or Town, S	State, Zip Code)
		Gertrude Henson Ma	rshall/Mother	7311 S	hadv Glei	n Terrac	e Capito	ol Heigh	ts, MD 20743
altimore, rmit. Pages 1 ar partment of Hee portant: If item y injury or othe		20a. Method of Disposition	20b. Plac		ion (Name of tory or other place		Date		City or Town, State
Pages nent of ant: If its		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	urecti		3/4/	2009	Clinton.	Maryland
Baltimo permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Licety			Name and Address				
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		23a. Part 1. Enter the disease, or composhock, or heart failure. List only	olications that caused the death.	Do not enter	the mode of dying	, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
Physician	4	Immediate Cause (Final disease or condition	MYOCARD	· (A)	INFAR	CTION			Onset and Death
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sit s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or se a consequer						
xecut and I-tran	xarr	that initiated events resulting in death) Last	c. HSPERTE				·		
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Box death cer attendir	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea		Ectopic pregnancy Other <i>(specify)</i>			Mor	
I Records, P.O. Box 68/60, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/	9 Unknown	9 Unknown						
s that ned t	by P	Part II. Other significant conditions of	ontributing to death but not resulti	ing in the und	erlying cause give	n in Part I.	23e. Did t	obacco use contri	ibute to the cause of death?
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aw re	Completed						24a. Was		Vere autopsy findings available prior to completion of cause of
The I	Eo						perfo	rmed? d	leath? □Yes 2□No
	Be C	25. Was case referred to medical examiner?				26. Place of Dea			
Of V Physic this ce al direc	10 E	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☑ EF	R/Outpatient	3 □ DOA Othe	r: 4 ☐ Nursing H	ome 5 ☐ Resi	dence 6 Othe	er (Specify)
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or At frer d frer d Direct	Certification:	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, farm, stree	t, factory, office		City or To		er or Rural Route Number,
Hospital or 24 hours afte Funeral Dir rtely filled in		200 Cartifier (Cartifulna Bh	ysician: To the best of my knowl	ladge death	occurred at the tim	a data and place	and due to the	cause(s) and ma	anner as stated
Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the th	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	niner: On the basis of examination and manner stated.	on and/or inve	estigation, in my or	pinion, death occu	rred at the time,	date and place, a	and due to the cause(s)
To the within 2 To the comple	Mec	29b. Signature and title of certifler			29c. License	number	T	29d. Date signed	(Month, Day, Year)
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54		30. Name and address of person who	W-21 .	23a) (Type, Pi	rint)				
' 2)		ERIC ANTWI-D		PIS	CATAWAY	ROAD	SUIT	E 750,	CLINTON,

State Registrar

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

of Vital Records,

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** MARGHRET HIL Z 2009 755 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHESAPEAKS MEDICAL HARFURD If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 F Days Months Hours Min. 102 Director 213-34-1987 2/28/1906 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ?7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Wedforl Even four must be notified at **Funeral Director** 1 XYes 2 No MD. Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21218 706 East 36 Street United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ∐Yes 2 X No 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Winfield John Preston Clara ဂ W. Kunkel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17361 19a. Informant's Name/Relationship (Type. Print) 02/00/00 25 Eastwood Drive Shrewsbury, Penna. Kenneth R. Klein (Nephew) or other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages
Department of
Important: If It
any Injury or c 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Bethel Cemetery 3/10/2009 Madonna, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E.G. Kurtz & Son Funeral Home, P.A. Jarrettsville, Maryland 23a. Part 1. Enter the disease, or complications that cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** > I day COMA /Medical Due to (or as a consequence of): ANDER MORGAREE MINOSOSSIUN #23% Division of Vital Records, P.O. Box 68760, Examiner SHURTMESS Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? φ 2 1 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an 1 ☐ Yes 2 MNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ne Hospital or Attending Ph n 24 hours after death, ne Funeral Director: After th 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10053055 3/6/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)) 501 Union Avenue, Havre de Grace, MD 21078 Registra s Signature 31. Date filed (Month, Day State

DHMH 17 Rev 1/2001 15

DIT

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State	of Marylan		artment of F		Mental Hy		009	nΩ	163
	3.		Registrar 1. Decedent's Name (First, Middle	a (ast)		Cer	illicate of	Dealli	2. Date of D		005	3. Time of	Death
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	Examin	er	4a. Facility Name (If not institution		ımber)		4b. City, Town, o	r Location of De	ath	4c. Coun	ty of Death		
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	deatl ms 2	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U.	S. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origin?	(Specify Yes or N	USZ o- 14. R:	ace - Americ		
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Maryland 21215-0036	ould be Mental arked o	To Be	Paul Reuter					Nicko	olena Ro	ota			
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altin			4 □ Donation 5 □ Other (S 21. Signature of Funeral Service		Ard	ent Cr	ematory : Name and Addre	Inc.: 3/	2/2009	Hanov	er,Md		T
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387	physicate by the by	edical		d									
Вох	death certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant		utcome pf pregna		Je.,			23d. E	ate of delive	ery	
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Division or	l or Att after de Direct d in by t	Certification:	3 Suicide 6 Could 4 Homicide determ	ined 28e. Plac	e of injury - At ho ding, etc. (Specify	ome, farm, str y)	eet, factory, office		28f. Location City or To	(Street and Num own, State)	nber or Rura	l Route Numb	ber,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifylin (Check only one) 1 Medical	ng Physician: To the Examiner: On the and ma	ne best of my kno basis of examina nner stated.	wledge, death	n occurred at the til vestigation, in my o	me, date and pla opinion, death oc	ace, and due to the courred at the time	e, date and place	manner as s e, and due to	tated. the cause(s))
	To the within To the complete	Me	29b. Signature and title of certifie	r C		./	29c. Licens	e number		29d. Date sign	ned (Month,	Day, Year)	
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(5)	100		30. Name and address of person			, , , , ,							
	Sta	to	Dean S. Tippet 31. Date filed (Month, Day, Year)	_ 32	600 Will Registrar's Signa	A	re. Balti	more,Md	. 21229				
	Registr	ar	31. Date filed (Month, Day, Year)		ineva	B. 1	arkel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 27,2009 Year Bekelech Kidanekal 1945 P February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Prince George Laurel 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 🖼 F 18,1936 Director 215-39-6740 May Ethiopia Usual Residence of Decedent 10a. State 10b. County show 10c. City. Town or Location 10d. Inside City Limits event, the Midical Exercises hast be notified at Director 1√Yes 2 No 28a-f Maryland Prince George Laure1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ō 14404 Westmeath Drive 20702 Ethiopia 23a 72 hours after death Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 至之No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married P Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ Specify: African 3 X Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Unknown None Housekeeper Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be 1 Health and Mental Kidane Kal Yefrye ဂ္ Enkenieleshe Woldesadeke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sosena Asrat/Daughter 14404 Westmeath Drive, Laurel, Maryland 20702 permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once. Baltimore, 20c. Location - City or Town, State Addis Ababa, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) March **IXX**Burial 2 ☐ Cremation 3 **X** Removal from State 4 Donation 5 Other (Specify) Ababa Cemetery 2009 Addis Ethiopia 22. Name and Address of Facility Robert G. Mason Funeral Home Inc 21. Sign there of Funeral Service License 1661 Good Hope Rd SE, Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): death certificate be executed burial-trar Due to (or as a consequence of): Box 68760 physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) Ö 9 Unknown 9 🗌 Unknown ed by t ۵. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? aw 24a. Was an has 2 autopsy page performed certificate 1 ☐ Yes 2X No 1 ☐ Yes 2 √ No After this certification funeral director, p Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Hospital or Attending 1 🔀 Natural to Euneral Director: A bletely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

State Registrar

completely

within 2 To the the

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

MD Lee-Llacer Lorayda Laurel Regional Hospital 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) March 3, 2009

7300 Van Dusen Rd.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 23°, James Long E. February 2009 9:44 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | June 14, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Year) 1921 Months Days 1 ₩ M 2 🗆 F 246-12-4446 87 North Carolina Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 1√Yes 2□No District of Columbia Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 20018 3298 Fort Lincoln Drive, NE United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔼 No
If Yes, Give
Year or Dates: Black White etc 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No **Black** Specify Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) vears Aircraft Service Worker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julius Long Gertrude (Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 503 Barrymore Drive Oxon Hill, MD 20745 Mark A. Long, Sr. - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Lee's Crematory Mar 4, 2009 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funer I Servi 4001 Benning Road, NE Washington, DC 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DIOPULMONA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): EUMONIA Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛐 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 🔀 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2⊠ No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manner of Death

Physician /Medical Examiner

requires that the death certificate be executed

The

Physician:

Hospital or Attending

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Director: the

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To the Funeral

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Box 68760.

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Division of Vital Records,

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Department of Health ar
Important: If item 27 is
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3altimore, Maryland 21215-0036

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Exami Physician/Medical þ Completed Be

burial-tran physician the attending pl the detached signed by t icate has been s ; page 2 should l certificate director, Certification: To this After 1

3 Suicide

(Check only one)

29a. Certifier

1 X Natural 5 Pending

investigation 2 Accident 6 Could not be determined 4 Homicide

28a. Date of Injury (Month, Day, Year) 28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

3

29c. License number

29d. Date signed (Month, Day, Year)

MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

Physicia /Medic For State Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	1. Decedent's Name	(First, Middle	, Last)						2. Date of Death			3. Time of Death
n	Eugene	Leroy 1	Meekins					F	Month ebruary	25 .	Year 2009	21:23 PM
al er	4a. Facility Name (II	f not institution	give street and num	ber)		4b. City, Town, o	Location		Coldary		y of Death	
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	5. Social Security No		6. Sex 7 11 M 2 □ F	. Age (In yrs. la		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Y	ear)	9. Birthp	lace (State or Foreign try)
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rec	10e. Street and Nun					10f. Zip Code			10g	. Citizen of	What Coun	try?
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Jera	13 Manas	ssas Dr	12. Was Deced	ent Ever in U.S	. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Ori	gin? (Spec	cify Yes or No-	14. Ra	ed St ace - Americ	an Indian,
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	19a. Informant's Na Richard M									•		21921
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		☐ Cremation	3 Removal from St	ce.	metery, cřel	matory or other plac		larch	· ·			
	21. Signature of Ed			Ce	meter	t Method: 2. Name and Addre	ss of Facilit	20 <u>09</u>	ouch Fun	<u>rth E</u> eral	ast. Home	Maryland
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	23a. Part 1. Enter th	he disease, or	complication that cal	used the death.	Do not en	ter the mode of dyir	ng, such as	cardiac or	respiratory arrest	÷		Approximate
	shock, or hea Immediate Cause (only one callse on ea	ch line.			_ ^				[]	Interval Between Onset and Death
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Medical Certification: To Be Completed by Physic	C 22 5		A 1 -0-		-	e she		in a	1 Tres			ably 4 ☐ Unknown
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erti	4 🗌 Homicide	determi		g, etc. (Specify)		, ,,			City or Town, S			,
a S	29a. Certifier	1 Certifyin	g Physician: To the b	est of my know	rledge, deat	th occurred at the ti	me, date ar	nd place, a	nd due to the cau	se(s) and r	nanner as s	tated.
dic	(Check only one)	2☐ Medical I	Examiner: On the ba		on and/or in	nvestigation, in my o	pinion, dea	th occurre	d at the time, date	and place	, and due to	the cause(s)
Me	29b. Signature and	title of certifier	-	-		29c. Licens	e number		29d	. Date sign	ed (Month,	Day, Year)
	Me	mili	I wen'		M	DID,	70	637	30	2/2	510	99.
	30. Name and addr	ess of person	who completed cause	of death (Item	23a) (Type,	Print)					-	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2009

08166

Reg. No.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician MAW DORIS February 26,2009 11:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ASPENWOOD SR. LIVING SILVER SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday Funeral Days 1 □ M 2 🔀 F 198-32-7368 96 Director April 4 1912 Canada Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Md. Olney Montgomery 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20832 19440 Olney Mill Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: þ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) University Secretary 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hazel Goff Lockhart Arthur ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19440 Olney Mill Road, Olney, Md. 20832 Heather M. Hoiberg / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crem. 2/27/09 Alexandria, Va. 4 Donation 5 Other (Specify) 21. Signature of Fyror ral 5 Tyrce Licens 22. Name and Address of Facility
Muriel H. Barber Funeral Home M-00470 P. O. Box 5038, Laytonsville, 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypoxemia 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Failure to Thrive 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform rmed? 2 ☑ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Living 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 5 ☐ Pending investigation 1 🗷 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mother 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Olney, 20832 Maryland Ata Motamedi, M.D. 17904 Georgia Avenue, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 3 2009 parke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Homer Kenneth Markline 25 February 2009 6:50 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, NOV 22 Birthplace (State or Foreign Country) Funeral Year) 1928 Months Days 1 🔀 M 2 🗆 F Hours 216-28-6833 Director 80 Nov Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits ral", or items 23a or 28a-f shov Evaruiner must be notified at Director MD Carroll Finksburg 1 ☐ Yes 2 ☐XNo 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21048 Trailer #23 2525 Baltimore Blvd USA permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any Injury or other traumatic event, the Medical Examines must Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 2 1 ☐ Yes 2 🕱 No Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry c than " Elementary/Secondary (0-12) College (1-4or 5+) Black & Decker Painter 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Markline Elma Greaser ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2525 Baltimore Blvd Finksburg, MD 21048 Marion Markline/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 02/27/2009 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Church Cem Upperco, MD 21. Signature of Funeral Service Licenses Pritts Fureratione and Chapel, P.A. 7 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any leading limits of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by cate has been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has autopsy performe 1 ☐ Yes 2 DN 2 🗆 No Physician: 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NO VE 1 Yes 2 LA Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner 1 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending HOUSE 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Medical 1 Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

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Division of Vital

State Registrar 29b. Signature and title

31. Date filed (Month, Day, Year)

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and manner stated

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

0054218+ 02-26-09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ____2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** Thompson Madison 8:00 A Feb 25, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 9011 School Way Fort Washington Prince George's 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral X**X M 2□ F Days Hours Min. Months Director 232 52 9654 72 Oct 17, 1936 Virginia Usual Residence of Decedent 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Medical Examination or notified a 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2□No Director Maryland | Prince George Fort Washington 10e, Street and Number 10g. Citizen of What Country? 9011 School Way Funeral United State 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) filed within 7 I Hygiene. other than "r Elementary/Secondary (0-12) 12 College (1-4or 5+) U.S. Government Auditor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fred Johnson Madison ည <u>Virginia</u> Thompson permit. Pages 1 and 2 shu Department of Health and Important: If Item 27 is m any injury or other traum 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce T. Madison (WIFE) 9011 School Way, Fort Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place March 2, 2009 20a. Method of Disposition 1 Durial 2 ☐ Cremation 3 ☐ Removal from State Christ Episcopal Church Cemetery Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Licensee, Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse juence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. 9 Unknown is been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 🗌 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier D46478 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar uresh

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Sungths Rel, Clinton, mp 20735

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Medical Examiner		11011011	ller_	14	o. City, Town	or Locati	on of Deat		/ 19, 2009 4c. Co	ounty of Deatl	1
	acility Name (if not institution 2132 Alice Avenue #3		er)	41	Oxon Hill		On or Boat	W = 2		ce George	
	ocial Security Number		Age (In yrs, last birth	nday)	If Under 1 \		Jnder 24Hr	s. 8. Date of I	Birth (MM/DD/	YYYY) g. Bir Forei	thplace Shiffigton
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or items 23	T.7	Armed Force		If Ye	es, specify Cu	uban, Mex	tican, Puer	to Rican, etc.)			
safter dans anner m		vorced If Yes, Give Year			Yes 2 X			f work dono		ecifyAfri d of Business	can America
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more, MD 2 ages I and 2 shou not of Health and N utt. If iteus 27 is in	Carl A. Mille	r - Father	20b, Place	of Dispos	ition (Name			Date	20c. Lo	cation - City	or Town, State
Ore, of He ther the	X _{Burial} 2 Cremation	on 3 Removal from			her place)	1 Dar	-le Ma	r 2, 20	09 T.a	ndovei	MD
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Balt permit. Departi Import Injury	10 h a dal	THE WAT	TAA	40	001 Be	nning	Roa	d. NE W	ashing	ton, I	C 20019
Physician 23	a. Rat I. Enter the disease, of failure. List only one caus	or complications that cause on each line.	ised the death. Do n	ot enter t	he mode of d	ying, sucl	n as cardia	c or respiratory	arrest, shock	k, or heart	Approximate Interva Between Onset and Death
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or	condition resulting in death)	Due to (or as a c	onsequence of):								
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P.O. Box 68760 res that the death certificate signed by the attending physic be detached for use as the bid by Physician/Me	past 12 months?		nt at time of death	2	etal death other (Specif		Lotopio pio		_		
Box e death c the atten the atten ed for us	Yes 2 No 9	Jnknown 9 Unknow						220	Did tobacco u	ne contribute	to the cause of death?
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Division o' spial or Attending outs after death. meral Director: After filled in by the fune Certification:	4 V Homicide	etermined (Specify)	Multi-Family A				_	2132 Alic	e Avenue #		
Hosp 24 ho Fune etely f	9a. Certifier 1 Certifying	Physician: To the bes	t of my knowledge,	death occ	curred at the t	ime, date	and place eath occur	, and due to the red at the time,	cause(s) and date and pla	d manner as ice, and due t	stated. to the cause(s)
		and manner si	tated.			License r					(Month, Day Year)
2 2	9b. Signature and title of cer	M-				O.C.M		OCME	Feb	ruary 20,	2009
5 -	30. Name and address of per	LINTO)	The New 1stem 23							-	
\$	Theodore M. King,		ant Medical Exa	aminer	111 Pe	nn Stre	et, Baltir	more, MD 2	1201		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 10:08PM SIE /Medical 4a Eacility Name (If not institution, give street and number, City, Town, or Location of Death 4c. County of Death **Examiner** APOLIS If Under 24 Hrs. 9. Birthplace (State or Foreign - Country) 7. Age (In yrs. last birthday, 8. Date of Birth Month, Day **Funeral** Days Min. Hours 1 ☐ M 2 💢 F 82-2706 Director DOUTH Carolina Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1XYes 2 □ No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 20010 Items 23a 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status ural", or Item Black, White, etc. 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by Black 3 ☐ Widowed 4 ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, PO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical and 2 should be filed within lealth and Mental Hygiene. m 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) ousekeeper 18. Mother's Name (First, Middle, Maiden Surname. 17. Father's Name (First, Middle, Last) Be an ar ျှ NIECE 19a, Informant's Name/Belationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, #1106 Laure 1 MD 2070 Department of Health a Important: If item 27 is any Injury or other tra Jackson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20c. Location - City or Town, State 1 🗌 Burial 3 ☐Removal from State Ardent Cremator Other (Specify) of Fu 22. Name and Address of Facility MidAtlantic Cremation Society Belle foint Drive Ste & Green belt MD 20170 23a. Part1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death or complications that caused the death List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final EUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) IMMUNO DEFICIENCY VIRUS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence Examine law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 LUNG CANCER Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1☐ Yes To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: Other: 1 ☐ Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DDA Nursing Home 5 Residence 6 ☐Other (Specify) After this 27. Magner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No death. Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of etifier 29c. License number 29d. Date sign of (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month EB. **Physician** 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Salisbury
HUnder i Year | Hunder 24 Hrs.
Days | Hours | Min. Road EAST WICOMPCO 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1 M 2 KF -18-DIO Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I're Medical Examinational be notified at once. 10d. Inside **⊄**ity Limits 10b. County 10c. City, Town or Location 10a State 1 Yes 2 □ No Funeral Director a 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number g S A vaa 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Yo Specify BIACK Completed by 3 Widowed 4 ☐ Divorced Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) HouseKeeping Elementary/Secondary (0-12) College (1-4or 5+) tomemakeR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be adie MASON NOWN ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 351A Mt.P. 57. (PA 19320 ene oatesuille HINES -NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State Direct Crematory LIC 2-26-09 Dover, DeLaware 4 ☐ Donation 5 ☐ Other (Specify) 917 W. Isabella St. ma Salisbury Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused th shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Concor **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner attending physician and Due to (or as a consequence of): The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law requir within 24 hours after death.

To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should I Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 8 No Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 280. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Coastal 31. Date filed (Month, Day, Year) Registrar's Signature State FEB 27 2009 sarko Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Mary			t of Health and e of Death	d Mental Hy	/giene Reg. No.	2009	08173	
			1. Decedent's Name (First, Middle, Las	st)				2. Date of D	eath Day	Year	3. Time of Death	
н	Physici /Medic		Muriel J. Mo	rgan				March	_ ′	2009	2119 M	
ř	Examin		4a. Facility Name (If not institution, give			4b. City,	Town, or Location of D			County of Deatl	h	
1			Prince Georges	Hospital			Cheverly		Pr	ince_	Georges	
	Funeral		Social Security Number 6. S	ex 7. Age (lr ☐ M 2 ☑ F	yrs. last birthday)	If Under Months		Ain. (Month, D	irth a <i>y, Ye</i> a <i>r)</i>	9. Birth Co.	hplace (State or Foreign untry)	
	Director		579-64-9857 Usual Residence of Decedent	- W 2M	62 Yrs.			Oct.	3,194	16 Wa	sh.,DC	
	and w		10a. State 10b. County	10	c. City, Town or Lo	cation					10d. Inside City Limits	
	Mary	ō	Md. PG		Clint	on					1 ☑ Yes 2 ☐ No	
	the 28s	Director	10e. Street and Number		CTTII	10f. Zip	Code		10g. Citiz	en of What Co	untry?	
	3a or		5014 Plata Str	oot.		2	0735		Unit	ted Sta	ates	
	death ms 2	Funeral	11. Marital Status	12. Was Decedent Ever	r in U.S. 13.	Was Deced	lent of Hispanic Origin'	(Specify Yes or N		4. Race - Ame	rican Indian,	
စ	after or ite	F	1 ☐ Never Married 2 ☑ Married	Amed Forces? 1 ☐ Yes 2 ☑ No			offy Cuban, Mexican, P	uento Alcan, etc.)		Black, White	e, etc.	
ဓ္ဓ	eral',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes :	No Specify:		, , ,	Specify: Bla	ack	
ည်	within 72 hours after death with the Maryland ene. than "netural", or items 23a or 28a-f ahow ha Madical Exertiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra		(Give	kind of wor	al Occupation rk done during most of	working	16b. Kin	nd of Business/I	Industry	
2	ne n	m ig	Elementary/Secondary (0·12)	Coifege (1-4or 5+)		DO NOT us				D .		
2	illed wi Hygien other th	Be	12 17. Father's Name (First, Middle, Last)		l.	lomem		Name (First, Middl	e Maiden	Privat	te	
auc	ntai hed of									Jamano,		
Ž	2 should be filed within 72 hours after death with the Marylan and Menial Hygiene. Is marked other than "natural", or liems 23a or 28a-1 ahow aumatic avent, it a Madical Examinating must be notified at	ြ	Emmett DeFore		19b. Mailii	na Address	Glady (Street and Number of			Town State 2	Zip Code)	
Maryland 21215-0036	ges 1 and 2 should to f Heelth and Men if item 27 is marke or other traumatic		William Morgan	/1 1 1	5014	Pla	ta Street	t	ou, ony or	, , , , , , , , , ,		
ē,	Heelth tem 27 tother tra		20a. Method of Disposition	/ Husband 2	20b. Place of Dispo	tor sition (Nan	MD. 2073 ther place)	3.5 Date	20c. Loc	cation - City or	Town, State	
Baltimore,	permit. Pages 1 a Department of Hee Important: if Item any injury or othe once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐	Inditional Itolii State			s Cemeter	13/09	Chel	tenhar	m. MD.	
	permit. Pag Department Important: Imy injury once.		21. Signature of Funeral Service Licer				d Address of Facility					
ñ	permit. Departr imports any inje		1 (mnice)	Edward			ilver Hi					
			23a. Part . Enter the disease, or com shock, or heart failure. List only	plications that caused the							Approximate Interval Between	
	The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed to the law representation to the law repre		Immediate Cause (Finaf disease or condition								Onset and Death	
			resulting in death)	a. <u>Septice</u> Due to (or as a co								
			Sequentially list conditions,	b. Metasta	tic Bre	Breast Cancer						
		ner	r any, leading to immediate cause. Enter Underlying	insequence of):								
		Examiner	Cause (Disease or injury that initiated events resulting in death) Last									
3760,	ate be ex hysician a the burial		rooming in down, and	Due to (or as a co	onsequence or):							
87	physicate to physical street.	dical		d						1	-0/ 	
9 X	ding	Physician/Med	IF FEMALE:	23c. If yes, outcome of p	regnancy			31/2/	2	3d. Date of defi	nua.	
Box	atter for u	cian	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 2☐ 4☐Pregnant at time	Fetaf death 3	Ectopic pr			-	Month Month	Day Year	
P. O.	the d y the iched	ysi	1 Yes 2 No 9 Unknown	9□ Unknown		3 0 11741 (0)2						
σ.	ires that the death certific signed by the attending p d be detached for use as	y P	Part II. Other significent conditions of	ontributing to death but n	ot resulting in the u	nderlying c	ause given in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?	
rds	quires n sign	d by						1	Yes 2	No 3∏Pro	obabíy 4 Unknown	
S	sw requires s been si should I	Completed						24a. Wa		24b. Were au	topsy findings available completion of cause of	
æ	The la te ha							per 1 Yes	opsy formed? 2 Z No	death?	-1	
a	an: rtifica tor. p	0	25. Was case referred to medical				26. Pface of	Death (Check only		7 2 100		
>	nysici lis ce direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospitaf: 1 Inpatient	2 ER/Outpatie	nt 3 00	A Other: 4 Nursir	ng Home 5 ☐ Re	sidence 6	Other (Spec	cify)	
0	ng Pt fter th neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time o				d. Describe how injury occurred			
Sio	Attending Physician: r death. sctor: After this certific by the funeral director.	atic	2 ☐ Accident investigation			М	1 ☐ Yes 2 ☐ No					
Division of Vital Records,	i or Att after d Direct i in by i	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 6 ☐ Could not be building, etc. (Specify)				, office		n (Street and Number or Rural Route Number, Town, State)			
0	urs af			<u> </u>								
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medicai	29a. Certifier 12 Certifying Ph (Check only 2 Medical Exar	nysician: To the best of m niner: On the basis of ex- and manner stated	amination and/or in	h occurred vestigation	at the time, date and p , in my opinion, death o	lace, and due to the occurred at the time	e cause(s) : , date and	and manner as place, and due	to the cause(s)	
	o the	Me	29b. Signature and title of certifier	2.10		290	c. License number		29d. Date	signed (Month	h, Day, Year)	
	⊢ s ⊢ ŏ		1	MANIN			D0026024		Max	ah 1	2009	
	1		30. Name and oddress of person who	completed cause of death	h (Item 23a) (Tyne				Mar	ch 4,	2009	
	5				100000000000000000000000000000000000000	200000	NE Wast	dnoton	DC	20015		
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's	Signature		, NE, Wash	rigcon,	ЫÜ	20017		
	Regist	rar	MAR 1 6 2009	and a	A. Mark							

09-01725 Ruth Evelyn Ortiz

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 08174

		- For State tegistrar		Certificate of	of Death			teg. No.		
Physicia ledical Examir	cian/ 1. Decedent's Name (First, Middle,Last) Mon Ruth Evelyn Ortiz 2. Date Mon Feb						2. Date of Dea Month February	Day Year 28, 2009	3. Time of Death 1513 hrs	
		,,				Town, or Location of Death Deposit Cecil				
Funeral		5. Social Security Number		n yrs. last birthday)	If Under 1	Year If Unde	Min	irth(MM/DD/YYYY) 9.	Birthplace (State or reign New York Country)	
Director		046-52-1039 Usual Residence of Decedent	1 M 2 X F	52 Y	rs.		July	26, 1956	Country)	
, any	ł	10a. State 10b. County	10	c. City, Town or Loc					10d. Inside City Limits 1 X Yes 2 No	
land f show	ţ	, , , , , , , , , , , , , , , , , , , ,	ecil		Per 10f. Zip Co	ryvill		10g. Citizen of What 0		
ith the Maryland 23a or 28a-f show any notified at once.	Director	10e. Street and Number 300A Carter C	Court		21903			U.S.	·	
with the ms 23a be noti		11. Marital Status	12. Was Decedent Ev			f Hispanic Orig	in? (Specify Yes or N Puerto Rican, etc.)	o- 14, Race - Ar White, et	merican Indian, Black,	
or death	Funeral	Never Married 2 Ma 3 Widowed 4 X Div	Arried 1 X Yes 2 vorced If Yes, Give Year 197	No			Hispanic	Specify:		
urs afte	d by	15. Decedent's Education (Spec		eted) 16a. Deced		upation (Give	kind of work done	16b. Kind of Busine	ess/Industry Yland Health	
6 n 72 ho an "na ical Ex	Completed	Elementary/Secondary (0-12)			esearch			l Care	System int, Maryland	
-003 d withii rgiene. ther the	mo.	17. Father's Name (First, Middle,					's Name (First, Middle		int, naryrana	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be		an Ortiz	[40]: A1-1		Direct and No.	Laura [oiaz umber, City or Town, S	State Zin Code)	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other transmatic event, the Medical Examiner must be notified at once.	٩	19a. Informant's Name/Relations Melody Fayer	ship (Type, Print) (daughter)	1115	Aiken	Ave., E	Ext., Perry	ville, Ma	ryland 21903	
Te, N Land 2 Health Fitem		20a. Method of Disposition 1 Burial 2 Cremation	n 3 Removal from State	20b. Place of Disp crematory or	other place)		Date	20c. Location - Cit West Ch		
Baltimore, permit. Pages I ar Department of Hes important: If ite		4 Donation 5 Other S	pecify:	R.A.Ferr			03/03/09		ylvania	
Baltimo permit. Page Department Important: injury or ot		21. Signature of Funeral Service	HALHEMON.) ()	Per	rvville	e. Marvland	Funeral Ho 21903-0	ome, P.A. 766	
Physician		23a. Part I. Enter the disease, or failure. List only one cause	r complications that caused the on each line.	e death. Do not ente	r the mode of c	ying, such as o	ardiac or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and	
M dical xaminer		Immediate Cause (Final disease or condition resulting in death) Death Death Due to (or as a consequence of):								
		Sequentially list conditions, b.								
if any, leading to immediate Due to (or as a consequence of): Cause. Enter Underlying Cause										
t ted		(Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
d. UNPENDED AMENDED AMENDED AMENDED 23C If yes, outcome of pregnancy										
3760, ifficate be ug physic sthe bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in t	23c. If yes, outcome 1 Live birth	of pregnancy	Fetal death	3 Ectop	c pregnancy	23d. Date of de Month	livery Day Year	
Box 68's death certificate attending ed for use as	sicia	past 12 months?	4 Pregnant at tir		Other (Specify)				
D. Bo tr the de by the		Part II. Other significant condi	oo	out not resulting in the	ne underlying ca	use given in P		-	ite to the cause of death?	
ords, P.O. B v requires that the d s been signed by the should be detached	ed by					-			Probably 4 Unknown are autopsy findings available	
cords law requestable been table	Completed					_		topsy prio	or to completion of cause of high?	
tal Rec ian: The l certificate l		25. Was case referred to medical	al lea		26	Place of Death	1 Yes	s 2No 1 •	Yes 2 No	
Vital hysician this cert	To Be	examiner?	Hospital: 1 Inpatient	t 2 ER/Outpat		Other:	Nursing Home 5	Residence 6		
on of ' ending Ph ath. or: After t			28a. Date of Injury (Month, Day Yea Feb 28, 2009	/ 28b. Time ar) 1505 hrs	- , , l	c. Injury at Wor 1 Yes 2 ▼	 Driver aut 	e how injury occurred o auto collision		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification:	3 Suicide 6 Cou	uid not be	ry - At home, farm, s		ffice building, e			or Rural Route Number, City Road, Port Deposit, MD	
Di To the Hospital within 24 hours a To the Funeral completely filled	Medical Co									
To To con	Med	29b. Signature and title of certif	and manner stated.		i	icense numbe	r		(Month, Day, Year)	
		Morganie	The Shill	11- 11- 00:		D.C.M.E.		March 1, 200	J y	
10		30. Name and a dress of perso Margarita Korell MD.	Assistant Medical E	Examiner 11	Penn Stre	et, Baltimor	re, MD 21201			
S Regis	tate	31. Date filed (Month, Day, Year		s Signature	a. U. J					
DHMH 17 Rev 1/3		MAR U.O	2000	ORIGI	NAL			OCME	1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-01499 State of Maryland / Department of Health and Mental Hygiene Curtis G. Onley, Sr. 1- For State Certificate of Death Registrar Time of Death 2: Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 20, 2009 Year 0835 hrs **Medical Examiner** Curtis G. Onley

4a. Facility Name (if not institution, give street and number) Onley c. County of Death 4b. City, Town, or Location of Death Prince George's Clinton Southern Maryland Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Min Country) Marylan Director 3/12/1953 X M 2 Yrs 55 213-54-5112 Usual Residence of Deceden 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 XYes 2 No 28a-f show s 23a or 28a-f show e notified at once. Charles Indian Head MD with the Maryland Directo 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number USA 20640 5400 Mason Springs Rd 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican; etc.) 14. Race - American Indian, Black Funeral 12 Was Decedent Ever in U.S. 11. Marital Status White, etc. itens must be Armed Forces? Never Married 2 Married Yes 2X No 5 Black Specify: Baltimore, MD 21215-0036
pennit: Pages I and 2 should be filed within 72 hours after 1
Department of Health and Mental Hygiene. f Yes, Give Year Yes 2X No specify: Divorced 3 X Widowed traumatic event, the Medical Examiner it: If item 27 is marked other than "natural" other traumatic event, the Medical Examine \$ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Computer Tech. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elsie Lee Morton Be Onley Raymond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lusby MD 20657 <u>Millbridge Rd</u> 11691 Curtis G.Onley 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation Marbury Maryland rfant: 2/28/09 Pleasant GrooveCH Donation 5 Other Specify: Funeral Service Licenson 22 Name and Address of Facility . Signature o Adams Funeral Home, Aquasco MD 20608 191 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line Death Medical a. Pulmonary Thromboembolismo complicated by Multiple Injuries Immediate Cause (Final disease camine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED attending physician or use as the burial Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. ò Yes 2 V No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an has been prior to completion of cause of autopsy death? performed? No Yes 2 1 V Yes certificate 26 Place of Death (Check only one) the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certiff 25. Was case referred to medical Division of Vital Be examiner? Hospital: DOA Residence 6 Other Inpatient 2 ✓ ER/Outpatient 3 1 V Yes ို 28a. Date of Injury (Month, Day, Year) FOUND: 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 27 Manner of Death Certification: Driver auto fixed object collision FOUND: Natural Yes 2 ✔ No 1 Pending Feb 20, 2009 0745 hrs 2 V Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be or Town, State) 9900 Rosarville Road, Upper Marlboro, MD Suicide within 24 hours a To the Fineral I (Specify) Local Street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and title of certifie February 21, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Margarita Korell MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year, 32. Registrar's Signature

State

Registra

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09-01928 Ja

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ason M. Philpott		lelible Ink. Ensure All Copies Are Lo tment of Health and Mental Hygiene						
20017 Mil. 1 Pilipott	1- For State Certification Cer	ficate of Death	Reg. No. 2009 0817					
Physician/	1. Decedent's Name (First, Middle,Last)	2. Date of De Month	eath 3, Time of Death					
ledical Examine	bason flatenew fliftpote	March 7,	, 2009 2108 hrs					
	Facility Name (if not institution, give street and number) 7959 Telegraph Road	4b. City, Town, or Location of Death Severn	4c. County of Death Anne Arundel					
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last		Birth(MM/DD/YYYY) 9. Birthplace (State or					
Director	218-15-1077 1XM 2 F 26	Months Days Hours Min	26, 1982 Foreign Cheverly, MD Country)					
	Usual Residence of Decedent							
w any		own or Location	10d. Inside City Limits 1 X Yes 2 No					
Maryland 28a-f show datonce.	Maryland Anne Arundel Crof	10f. Zip Code	10g. Citizen of What Country?					
death with the Maryland or items 23a or 28a-f she must be notified at once Funeral Director	1460 Chatham Court	21114	USA					
with the same notine ral [
or items 2. must be n	1 Never Married 2 X Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	White, etc.					
ral", o	3 Wid owed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:	Specify: White					
5-0036 led within 72 hours a Hygiene. other than "natura the Medical Examin		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry					
5-0036 ed within 72 hour ygiene. the Medical Exattle Completed	Liennentary/Secondary (6-12)	Firefighter	Prince George's County Fire Department					
5-0036 iled within 7 Hygiene. I other than the Medica	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle	-					
21215-0 21215-0 201d'be filed w 1 Mental Hygic i marked othe ic event, the N		Gwendolyn F. I	The second secon					
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland the and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f she numatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) Gwendolyn F. Philpott / Mother	19b. Mailing Address (Street and Number or Rural Route N						
Baltimore, MD 2 permit Pages and 2 shoul Department of Health and M Important: If item 27 is in injury or other traumatic	20a. Method of Disposition 20b. Pla	ace of Disposition (Name of cemetery, Date	20c. Location - City or Town, State					
nore ages 1 nt of F it: If i	Fort	ematory or other place) t Lincoln Cemetery 3/14/2009	9 Brentwood, Maryland					
altin mit. P. sartine sortan	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	22. Name and Address of Facility						
E P P E	Goylle RAY Rugas	Gasch's Funeral Home, P.						
Physician Medical	23a. Part I. Enter the disease, or complications that caused the death. E failure. List only one cause on each line.	o not enter the mode of dying, such as cardiac or respiratory a	Between Onset and					
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D, be exe sician nurial -	X UNPENDED AMENDED 238,27,2	8a-t, perME, g889 3/1//09 TI						
Sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed that the center of the secutificate has been signed by the attending physician an by the funeral director, page 2 should be detached for use as the burial - transcription: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregna	ancy 2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year					
ox 6:	past 12 months? 1 Yes 2 No 9 Unknown							
Boy the att shed for the dor	Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause given in Part I. 23e. Dic	d tobacco use contribute to the cause of death?					
res that the signed by be detach		, , , , , , , , , , , , , , , , , , , ,	Yes 2 No 3 Probably 4 Unknown					
Records, P.C The law requires that ficate has been signed page 2 should be det		24a. Wa						
e law reque has been ge 2 should		per	topsy prior to completion of cause of death? s 2 No 1 Yes 2 No					
ital Recions: The certificate rector, page		26.Place of Death (Check only one)	s 2 No 1 Yes 2 No					
Vital hysician this certi	1 ✓ Yes 2 No Inpatient 2 E	ER/Outpatient 3 DOA Other Nursing Home 5	Residence 6 Other: Scene					
n of Nding Phy. After tl funeral			pe how injury occurred					
ivisior or Attence after death Director: I in by the	Pending Fd 3/7/09 Investigation	Fd 9:00 pm 1 Yes 2 X No unk	(Charles Alambar Barris Barris Alambar Char					
Division of Vital Records, spital or Attending Physician: The law requirmours after death. neral Director: After this certificate has been sinfilled in by the funeral director, page 2 should be certification. To Be Completed	3 Suicide 6 X Could not be determined (Specify) mobile	ne, farm, street, factory, office building, etc. 28f. Location or Town Severi	n (Street and Number or Rural Route Number, City n, State) 7959 Telegraphy Rd n, MD					
		e, death occurred at the time, date and place, and due to the ca						
To the Hos within 24 h To the Fun completely	one) 2 Medical Examiner: On the basis of examination and and manner stated.	d/or investigation, in my opinion, death occurred at the time, da						
F 3 F 3	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)					
	Carol Hallan	O.C.M.E.	March 8, 2009					
24	30. Name and address of person who completed cause of death (Item 2 Carol Allan, MD Assistant Medical Examiner 1	23a) 111 Penn Street, Baltimore, MD 21201						
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	0.0						
Registra	MAD 1 1 2000 21	pare						

Registrar DHMH 17 Rev 1/2001 OCME 2006

			Pl€ - For	ease Type or Pi State of I			delible Ink artment of H		•		egible.	0017
		1 - State Registrar Certificate of Death Reg. No.						2009	0817			
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Helen H.			, Penn			Month	2. Date of Death Month Day Year March 6 2009 09		
	Examin		4a. Facility Name (If not institution, give street and number) 108 Bowling Lane 5. Social Security Number 6. Sex 7. Age			Elkton ge (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.		8. Date of B	irth	ounty of Death Cecil 9. Birthp	place (State or Foreign	
	Director		159-01-3458 Usual Residence of Decedent 10a. State 10b. Cour		91	Yrs.	Months Days	Hours Min	SEPT 1	1, 191		ntry) Sylvania Od. Inside City Limits
	ne Maryla 8a-f shov pullied at	Director	Maryland Ce	cil	1	E1ktor	1					1 □Yes 2 🛣 No
	with the	Dir	10e. Street and Number	T			10f. Zip Code	1			en of What Coul	-
	eath v	eral	108 Bowling	12. Was Decede	ent Ever in U.S	3 13	2192		Specify Yes or N		ited St	
Baltimore, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. If Health and Mental Hyglene. Iften 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evantizer must be notified at	by Funeral	Armed Forces? 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced Armed Forces? 1 □ Yes 2 ▼ 1 If Yes, Give Year or Dates:		es? ∑ No		Was Decedent of H If Yes, specify Cub 1 □ Yes 2 ሺ No	rto Rican, etc.)	can, etc.) Blac Specify			
2-0	72 hou	ted	15. Deced	dent's Education ghest grade completed)		16a. Dece	dent's Usual Occup	pation	nrkina	16b. Kind	of Business/In	dustry
121	ithin 7 ne. han "r	Completed	Elementary/Secondary (0-12	·	or 5+)		kind of work done DO NOT use retire	d)	n King	T	II O	. 17
12	filed within Hygiene. other than "		12 17. Father's Name (First, Midd	de Last)		н	memaker	18. Mother's Na	me (First, Middl		Her Ow	n Home
ano	d be f ental ced o	To Be	Joseph Hethe						e Conno			
ary	2 should be f and Mental is marked oi aumatic eve	ř	19a. Informant's Name/Relation	-		19b. Maili	ng Address (Street				Town, State, Zip	o Code)
Ž,	1 and 2 Health a em 27 is		David Penn/S	on		726 I	Brook Cir	cle, Mor	ton, PA	1907	0	
ore	ë = = ē		20a. Method of Disposition	on 3 Removal from Sta	20b. P	lace of Dispo emetery, crei	sition (Name of matory or other pla	ce) Marc	h 11,	20c. Loca	ation - City or To	own, State
Ei m	. Pages tment of I tant: If its jury or o		4 □ Donation 5 □ Other				s Cemeter	y 2009)		ladelpl	nia, PA
Bal	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Servi	rice Licensee		Ĥ	Name and Address Home 03 W. St	e for Fu	nerals,	P.A.	14D 0	
	Physician		Immediate Cause (Final disease or condition	e, or complications that cau List only one cause on eac	h line.	n. Do not en		ng, such as cardia	ac or respiratory		, MD 2	1921 Approximate Interval Between Onset and Death
-	/Medical Examiner		resulting in death) Due to (or as a consequence of):									5
	or Attending Physiclan: The law requires that the death certificate be executed after death. After this certificate has been signed by the attending physician and birector: After this certificate has been signed by the tuneral director, page 2 should be detached for use as the burial-transit in by the funeral director, page 2 should be detached for use as the burial-transit.	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a consequ	uence of):						5 yrs.
Vital Records, P.O. Box 68760, 5			that initiated events resulting in death) Last	cDue to (or	as a consequ	uence of):						
		ed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	1 Live bir	th 2 ☐ Fetal nt at time of d	death 3	☐ Ectopic pregnan ☐ Other <i>(specify)</i> _	су		23	d. Date of deliv	ery Day Year
	quires that en signed b uld be deta		Part II. Other significant cond	ditions contributing to deat	th but not resu	ulting in the u	nderlying cause gi	ven in Part I.				he cause of death? bably 4 🗌 Unknown
	: The law requir cate has been s page 2 should	Completed							24a. Wa aut per 1 □ Yes	opsy formed?	24b. Were auto prior to co death? 1 □ Yes	opsy findings available impletion of cause of
Vita	iclan: The certificate ector, pag	Be	25. Was case referred to med examiner?	Hoepital					eath (Check only			
o	Phys r this ral dir	2:1	1 ☐ Yes 2 ☑No 27. Manner of Death	1 🗀 1 Ing		ER/Outpatie 28b. Time of		ner: 4 Nursing	Home 5 A Re-			fy)
on	rding I th. : After e funer	ation	1 🗷 Natural 5 🔲 Per	28a. Date of (Month, estigation	Day, Year)	Injury	f 28c. Inju Wo M 1 [rkí?]Yes 2. □No				
Division	al or Attend s after death Il Director:	Certification:	3 ☐ Suicide 6 ☐ Cou	uld not be ermined 28e. Place of building	Injury - At ho , etc. <i>(Specif</i>)	ome, farm, sti	reet, factory, office		28f. Location City or To	(Street and own, State)	Number or Run	al Route Number,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical (ifying Physician: To the b ical Examiner: On the bas and manne	is of examina							
	Vithi To t	Ž	29b. Signature and title of cert	A a				se number		73.4	signed (Month,	Day, Year)
			JA B	ullar mo	- 1			65013	•	3/6/	09	
	10		30. Name and address of personal John A. Billo	on, M.D., 204	4 Soutl	h Stre	,	on,MD 21	1921	_ •		
	Sta Regist		31 Date filed (Month Day Vo		tistrar's Signa	ture -						

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vear **Physician** Herschel Lee Permenter 2009 0635 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1851 Blue Ball Road E1kton Ceci1 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. Hours 1 X M 2 □ F Yrs. Director 218-32-1489 March 12, 1937 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanture must be morthly at once. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🙀 No Director Maryland Ceci1 E1kton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 1851 Blue Ball Road 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0036 1 □Yes 2 No Specify. <u>م</u> Specify: 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Production Foreman Composites Fabrication Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herman Permenter ပ္ Lena Susan McClung 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Warren H. Permenter/Son 4370 New Cut Road, Inman, SC 29349 20b. Place of Disposition (Name of Cherry Hill Methodist Cemetery 20a. Method of Disposition 20c. Location - City or Town, State March 11. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cherry Hill. MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, MD LLUTTUM 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): Lancer /Medical Examiner Tobacco Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑No Colon Cancer 24a Was an To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h completely filled in by the funeral director, page 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00065013 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) \mathcal{O}_{\prime} 204 South Street, Elkton, MD 21921 Billon, M.D. John A State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ^{Day} 2009 Physician March 8, 6:30 A. M Ilse Margarete Price /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford 635 Webb Street Aberdeen If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 3/23/1931 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 5. Social Security Number **Funeral** Hours Months Days 1 □ M 2 🔀 F 77 Germany Director 236-54-8532 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene.

m 27 is marked other than "natural", or items 23a or 28a-f show her traumatic event, the Medical Exprinct must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 XYes 2 No Directo MD Harford Aberdeen 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21001 U.S.A. 635 Webb Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2√∑No White Specify: ş 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Office Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mathilda Emig Heinrich Schanz 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a 21001 Robert S. Price (Son) 615 Gilbert Rd. Aberdeen, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o Burial 2 Cremation 3 R 3 Removal from State 3/13/2009 Harford Mem. Gdns. Aberdeen, Maryland ^{22.} Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 Approximate Interval Between Opset and Death 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cancier au **Physician** disease or condition resulting in death) /Medical months. Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Crise to for as a consequence of Examine Hospital or Attending Physlcian: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown ģ ۵. s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ⋧ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 □Yes 2 □No 1 ☐Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 602 S. Atwood Rd., Bel Air, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

Ashkam Bahrani,

31. Date filed (Month, Day,

09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-01856 State of Maryland / Department of Health and Mental Hygiene 2009 08180 Joann Parrott Certificate of Death 1- For State Reg. No. 3. Time of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day March 4, 2009 1938 hrs PARROTT Medical Examiner STONER JOANNE 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Harford Fallston 3208 Suffolk Lane 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number oreign **Funeral** Min. Days Hours Months Country) 68 ′1940 Director Penna 188-32-1841 1 M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Yes 2 X No FALLSTON Harford MD. filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21047 3208 Suffolk Lane 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or Nouneral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 Married 2 X No Yes White Specify: Divorced If Yes, Give Year 正 Yes 2 X No specify: 3 X Widowed or other traumatic event, the Medit at Examiner ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) If item 27 is marked other than 21215-0036 Politician Government Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Hess Stoner Kreider Brackbill Jacob 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1084 19a. Informant's Name/Relationship (Type, Print) Jarrettsville, Maryland Sharon Read 2850 Scott B. Parrott (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Baltimore, Nemit. Pages I and Department of Healt Important: If item injury or other tran 20a. Method of Disposition crematory or other place) Cremation 3 X Removal from State 15/2009 Lititz, Creek Cem. Middle Other Specify E.G. Kurtz & Son Funeral 22. Name and Address of Facility 21 Signature of Funefal Service Licensee Jarrettsville, Maryland 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and **Physician** failure. List only one cause on each line. Death /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last g physician and the burial - transit the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED **AMENDED** 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: Year Day 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Live birth certificate has been signed by the attending rector, page 2 should be detached for use as the past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o No 3 Probably 4 Unknown δ Records, P. Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? No Yes 2 V No 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be Other: Nursing Home 5 Residence 6 Other: Scene Hospital: ER/Outpatient DOA Inpatient 2 this ၀ 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 27. Manner of Death After Certification: 1 V Natural 1 Yes 2 No Division Pendina 24 hours after death Funeral Director: tely filled in by the Investigation 28f. Location (Street and Number or Rural Route Number, City 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 3 Could not be Suicide (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 1 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 6, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD. 31. Date filed (Month, Day Year) 32. Registrar's Signature State wen Gaman Registrar **ORIGINAL**

DHMH 17 Rev 1/2001 OCME 2006

			For State Registrar	State of Maryland	Depa / Depa	artment of Hertificate of L	ealth and Me Death	ental Hygie		08181
			Decedent's Name (First, Middle, Last,)				2. Date of Death		3. Time of Death
	Physici /Medic	_	Harolo	d Eugene Philho	wer,	Sr.		Month March	8 2009	1.4
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or			4c. County of De	eath
			Union Hospital	7 //	e late de 1	E1kton		Date of Birth	Cecil	N. 1. (O. 1. 5. 1.
	Funeral Director		175-44-9995	7. Age (In yrs. last	Yrs.	Months Days		B. Date of Birth (Month, Day, Yo NOV 27,	1951 M	Birthplace (State or Foreign Country) ary land
	and	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Lo	cation				10d. Inside City Limits
	Manyl 1 sho	ō	Maryland Cecil	F1L	ton					1 X Yes 2 □ No
	the r 28a	Director	10e. Street and Number	LIE	CLOII	10f. Zip Code		10g	. Citizen of What	Country?
	h with		348 Friendship Ro	ad		21921			United	States
	deat	Funerai		12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent of His	spanic Origin? (Spec	ify Yes or No-	14. Race - Ar Black, W	nerican Indian,
980	be filed within 72 hours after death with the Maryland ntal Hygiene. The Maryland at the "haturel", or Itema 23a or 28a-f show avent, the Medical Examinar must be notified at	by	1 ☐ Never Married 2 🐧 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 No 1971 If Yes, Give Year or Dates:	1	1 ☐ Yes 2 📉 No	Specify:	, , ,	Specify:	hite
2-0	72 ho	Completed	15. Decedent's Edu (Specify only highest grad		6a. Deced	dent's Usual Occupa	tion uring most of working	161	o. Kind of Busines	ss/Industry
2	within ene.	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	lite. I	DO NOT use retired,	omig modi or normi			_
121	e filed within al Hygiene. I other than ' vent, tra Ma		12 17. Father's Name (First, Middle, Last)		Ma	intenance	18. Mother's Name (Government
Maryland 21215-0036	고하호오	To Be	Charles Robert P	Philhower, Sr.				e Searles	,	
lan	2 sho and h ls ma		19a. Informant's Name/Relationship (Ty			•	nd Number or Rural		ity or Town, State	o, Zip Code)
	l and lealth m 27 her tr		Janet Philhower/W			riendship	Road, Ell		21921 c. Location - City	or Town State
Baltimore,	permit. Pages 'Department of thimportent: If ite any injury or ot once.		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ F	Removal from State Gill	etery, crem in Ma	natory`or other place	March	12,		
Ħ	nit. Pigartmer antmer portent influry		4 ☐ Donation 5 ☐ Other (Specify) 21. Signatulte of Funeral Service Licens	+ Memo	rial	Park	2009 s of Facility		E1kton	, MD
Ba	Depa Impo any i		1 Doniel -	8. dieko	H: 10	icks Home 03 W. Sto	s of Facility for Funer ckton Stre	rals, P.A et, Elkt	on, MD	21921
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ne cause on each line.			_			Approximate Interval Between Onset and Death
10	Physician		Immediate Cause (Final disease or condition resulting in death)	Carcino	ma c	of Bladder	with Mel	astasis		Umknown
	/Medical Examiner		Tosaking in accini	Due to (or as a consequen	ice of):	1				
	* * .	er	Sequentially list conditions, if any, leading to immediate	b	ice of):					
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	s.						
o,	ficate be executed physicien and s the burial-transit	Exa	resulting in death) Last	Due to (or as a consequen	ce of):					
38760,	ate be hysici	dicai	(d						
9	entifica ling pl	Med	IF FEMALE:	20. 16					T	
Box	eath certifi ettending for use as	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death	ath 3	Ectopic pregnancy			23d. Date of o	delivery Day Year
0	at the de by the e	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	1 5	Other (specify)				
<u>a</u>	that the post of t		Part II. Other significant conditions con	ntributing to death but not resulting	ng in the u	nderlying cause give	n in Part I.	23e. Did tobac	co use contribute	to the cause of death?
rds	quires in signi	ed by						1 🗆 Yes	2 No 3	Probably 4 Unknown
of Vital Records,	Physicien: The law requires that the death certifi this certificete has been signed by the ettending ral director, page 2 should be detached for use as	Completed						24a. Was an autopsy		autopsy findings available
Ä	The lav	E O						performed	death	o completion of cause of ? es 2 No
ita	icien: Th certificete rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)		
of V	Physic this co	၉	1 Yes 2 No		/Outpatien	nt 3□ DOA Othe	r. 4 Nursing Hom			pecify)
ou c	ding P h. After funera	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28	b. Time of Injury	Work	at ? ′es 2 □ No	3d. Describe how	injury occurred	
Division	or Attendi after death. Director: A in by the fu	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home	o, farm, str			3f. Location (Stree	t and Number or	Rural Route Number,
Ο̈́	al or At s after o	Certification:	4 Homicide determined	building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	301, 140101), 0.1100		City or Town, S		
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edicai (29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my knowle iner: On the basis of examination and manner stated.	dge, death and/or in	h occurred at the tim vestigation, in my op	e, date and place, ar inion, death occurred	nd due to the caus d at the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
	To the To the To the Complex c	Me	29b. Signature and title of certifier			29c. License		29d.	Date signed (Mo	
			Jachden	SM)		D23	322		3.11.	9
			20 Name and address of parent who as	ampleted squae of death (Itam 23	Ba) (Type,	Print) E	Cleson My	2/92/		
	Sta		S Sachder N 31. Date filed (Month Park ear) 6 2	32. Rigistrar's Signature	4	have		17		
	Registi	ar	7 4 0 6	Marine K	19	COLUMN TO THE PARTY OF THE PART				

DK Pt,

DHMH 17 Rev 1/2001

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			For State Registrar		State of M	arylan		artment of H rtificate of		Mental Hy	giene Reg. No. 2	009	08182
	Db		1. Decedent's Nam	ne (First, Middle, L	ast)					2. Date of D Month	eath Day	Year	3. Time of Death
	Physicia Medic!		Alvin		Leroy			Ruley		Feb		009	3. £ 24 a ^M
1	Examin		4a. Facility Name ('If not institution, gi	ive street and number)		4b. City, Town, o	r Location of Dea	ith	4c. Cour	nty of Deatl	
تحو			Souther	rn Mary	land Hosp	oita	<u> </u>	Clinto	on		Prin	ce G	eorge's
	uneral		5. Social Security N 578-52-		Sex 7. Ā 1 ☑ M 2 ☐ F		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, D	ay, Year)	Co	hplace (State or Foreign untry)
	irector		Usual Residence o	-0720		67	113.			03/23	/1941	Vir	ginia
land	show		10a. State	10b. County		10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
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th the	or 28	Director	10e. Street and Nu	ımber				10f. Zip Code			10g. Citizen o	of What Co	untry?
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r dea	ems er m	Funeral	11. Marital Status		12. Was Decedent Armed Forces	Ever in U	.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (an, Mexican, Pue	Specify Yes or N			rican Indian,
72 hours after death with the Maryland	ori	by F	1 ☐ Never Marr 3 ☐ Widowed	ried 2X Married	1 ∐Yes 2 🔀 If Yes, Give	No		1 □Yes 2 No	Specify:	·		ⁱⁱ ⁄Whi∶	
hour	tural		3 🗀 Widowed	15. Decedent's 8	Year or Dates:		16a Dece	dent's Usual Occup	nation		16b. Kind of		
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e filec	event, the Madical Examinar must be notified at	Be C	17. Father's Name	(First, Middle, Las	st)				18. Mother's Na	ıme (First, Middle			-
should b	arked atic e	P	James H	I. Ruley	7				Doroti	hy Smit	h_		
2 sho	EE		19a. Informant's N	lame/Relationship	(Type. Print)		1	ng Address (Street					
1 and Healt	m 27 her t		Deborah	Ruley/	/Wife	Tool		Castleto					
Pages 1	or of		20a. Method of Dis		☐ Removal from State	; [osition (Name of matory or other plac	i	Date	20c. Location	-	
it. Pa	ortant: Injury e.			5 Other (Spec	**	Tri	nity	Memoria		7/09	Waldo	rf, N	MD
Dena Dena	Important: If Item 27 is any Injury or other training once.		21. Signature of F	uneral Service Lice	ensee (VI)	040%	27	2. Name and Addre	ess of Facility Bi	riscoe-	Tonic	Fune	eral Home
-			23a, Part 1, Enter 1	the disease, or cor	mplications that cause	d the deat						dori,	MD. 20601 Approximate
			shock, or hea	art failure. List onl	y one cause on each	ine.		1	122				Interval Between Onset and Death
	sician edical		disease or condition resulting in death)	on	a. Due to (or a	FCV17		Lespiy,	mali	1011	nre		
	miner			•		en S	0	bile	tom	Portu	meni	No.	
75		je	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	onditions, nmediate		a conseq		0110	0011	70.(0	[01/03]		····
executed	nd transi	Examiner	that initiated events	S	c. Ch	ron	C	Pulmo	nan	filos	of s		
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cate	ng physician a as the burial	Physician/Medica			d. ItclU	1	120	Prate	y di	27 ret	2 show	con	٤
certif	nding se as	/Me	IF FEMALE:		23c. If yes, outcom	e of prean	ancv		*		004.5	Date of dat	
eath S	attendin for use	ciar	in the past 12	2 months?	1 ☐ Live birth 4 ☐ Pregnant	2 Feta	I death 3	☐ Ectopic pregnand ☐ Other (specify) _	СУ			Date of deli Month	Day Year
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s that	gned be deta	by P	Part II. Other signi	ificant conditions	contributing to death	but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco use co	ontribute to	the cause of death?
The law requires that the death certificate	s been signe should be		Cong	ESX' 4	heart		CLIL	m, C	us oni	1 🗆	Yes 2 No	3∏ Pro	obably 4 🗌 Unknown
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	page	Completed	ces	ton	disodo	0.	1+	V to 2 1	ention		ormed? 2 \hat{\hat{\hat{\hat{\hat{\hat{\hat{	death?	completion of cause of 2 \(\subseteq \text{No} \)
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Physi	.s. :≘	ဍ	1 ☐ Yes 2 🔀		-			nt 3 DOA Oth	4 □ Nursing	Home 5 ☐ Res			cify)
Attending Physician:	After	io.	27. Manner of Dear	5 Pending	28a. Date of In (Month, D	ury ay, Year)	28b. Time o Injury	Wor		28d. Describe	how injury occi	urred	
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affer	d in b	Certification:	4 Homicide	determine	d building, e	tc. (Speci	fy)	ooi, iaotory, omoo		City or To	wn, State)	noer or ria	rai nodie Nambei,
ospita hours	inera ly fille		29a. Certifier (Check only	1 Certifying F	Physician: To the bes	t of my kno	wledge, deat	h occurred at the ti	me, date and place	ce, and due to the	e cause(s) and	manner as	stated.
the Ho	To the Funeral Director; After th completely filled in by the funeral	Medical	one)	Z Medical Exa	aminer: On the basis and manners	or examina	ation and/or ir	vestigation, in my o	opinion, death occ	curred at the time	, date and place	e, and due	to the cause(s)
5 ±	70 CO TO	Σ	29b. Signature and	d title of certifier	intia.			29c, Licens		2	29d. Date sign		
			,	128	lo no	m	1)	100	0028	035	I-ch	. 0	4,2009
DB	12		30. Name and add	Iress of person who	o completed cause of	death (Iter	n 23a) (Type, <u></u> とひょこ	Print)	CVIS	5 Pr	scata TUN	MAY	Rd-#316 20735
	Sta Registr		31. Date filed (Mor	FEB 27	2009 32. Regis	trar's Signa	A. A.	parked					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar		,	Certificate of L			. No. 2 U U !	9 08183
Physic	ian	1. Decedent's Name (First, Middle,					2. Date of Death	Day Yea	3. Time of Death 3:03 PM
/Medi	ical	MARTHA M. 4a. Facility Name (If not institution,			4b. City. Town, or	Location of Death	Haron	4c. County of De	
Exami	ner	Washington (pital		rstown			ington
Funeral Director		5. Social Security Number 187–16–4238		je (In yrs. last birt		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	(ear) 9. E	Birthplace (State or Foreigr Country) Penna.
land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
Mary a-f sh	ţoţ	PA Lek	oanon	Jo	nestown				1 X Yes 2 ☐ No
th the	Director	10e. Street and Number			10f. Zip Code	-	100	. Citizen of What	Country?
ath wi		214 Rose I			1703			USA	
be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Items 23a or 28a-f show event, the "Acted Ever income to notified an	by Funeral	3℃Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1	No	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 💆 No		ecity Yes of No- Rican, etc.)	Black, WI	nerican Indian, nite, etc. White
natura lical	Completed	15. Decedent' (Specify only highes	s Education	16a.	Decedent's Usual Occupa	ation Juring most of worki	na 16	b. Kind of Busines	ss/Industry
Hygiene. Other than " ent, Its "	M M	Elementary/Secondary (0-12)	College (1-4or 5		(Give kind of work done of life. DO NOT use retired		Ι,	Manufac	turing
Hygie ther t	ပို	8 17. Father's Name (First, Middle, L	.ast)	A	<u>ssistant S</u>		OF 4 e (First, Middle, Ma		curing
and Mental and Mental s marked o umatic eve	To Be	1	,				ha Duple		
and Mental Hygi smarked other aumatic event,	-	19a. Informant's Name/Relationsh	ip (Type. Print)	19b	. Mailing Address (Street a	and Number or Rura	al Route Number, (City or Town, State	e, Zip Code)
ealth am 27 ls		Bertha C. (Olson		15 Oak Str				
Department of Health and Men Department of Health and Men Important: If Item 27 Is marke any Injury or other traumatic once.		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp			f Disposition (Name of ry, crematory or other place awn Mem. G	dns. 3	/7/09		burg, PA
Departr Importa any Inju		21. Signature of Funeral Service L	Brady			<u>Antietam</u>	Street,	<u>Hagersto</u> l	o. wn, Md. 2174
hysician /Medical xaminer		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. Due to or s b.	a consequence	pagenter A	condent			Approximate Interval Between Priset and Death Supplement of the Control of the Co
ng physician and as the burial-transit	Medical Examiner	Sauntially at conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence	Astey	. Olise	erc		Uh Phrus
by the attending ached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregrant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	1		23d. Date of o	delivery Day Year
in signed by the auld be detached f	ğ	Part II. Other significant conditio	ns contributing to death b		n the underlying cause give	en in Part I.	23e. Did toba 1 ∐ Yes		to the cause of death? Probably 4 D Unknow
ate has been signed by the attendi page 2 should be detached for use	Completed						24a. Was an autopsy performe	✓ prior !	
is certificate h director, page	Be (25. Was case referred to medical examiner?	Managhali		lou-		(Check only one)	· · · · · · · · · · · · · · · · · · ·	
rthis or	은	1 Yes 2 No	Hospital: 1 Inpation		trpatient 3 □ DOA Other	4 LI Nursing Ho	me 5 Residen		pecify)
death, stor: After i the funera	ij	1 Natural 5 Pending 2 Accident investig	(Month, Da	ay, Year)	njury Work	Yes 2 □No	20d. Describe now	injury occurred	
24 hours after deatl Funeral Director: tely filled in by the	Certification:	3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place of Inj	jury - At home, fa tc. <i>(Specify)</i>	rm, street, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
The freshman of averaging trippicans. Within 24 hours after death. To the Funeral Director: After this certification of the funeral director. After the funeral director, it is a few properties of the funeral director.	Medical C			of examination ar	e, death occurred at the tin nd/or investigation, in my o				
To the Ho within 24 To the Fu completel	Me	29b. Signature and title of certifier	969	- WD	1 -	1288		Date signed (Mc	inth, Day, Year) , 09 in M. M. J.
		30. Name and address of person	who completed cause of c	death (Item 23a)	(Type, Print)	HulA	. 1		20

DHMH 17 Rev 1/2001

DK

State of Maryland / Department of Health and Mental Hygier (2) 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** February 26, 2009 4:02 P Walter Russel Scofield /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Village Health Center Montgomery Village Montgomery If Under 1 Year | If Under 24 Hrs
Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Director 045-20-4260 82 May 18. 1926 Connecticut Usual Residence of Decedent filed within 72 hours affer death with fhe Maryland 10c. City, Town or Location 10d. inside City Limits 10a. State or 28a-f show item 27 is marked other than "naturel", or items 23a or 28a-f shot other treumatic event, the Madical Examination and the mail of the manual examination of the manual examina 1 ☐ Yes 2 📉 No Director VI Bennington Manchester Center 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 150 N. Ridge Run 05255 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Spacify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🂢 No Specify: Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Landscaper Landscaping 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill iment of Health and Mental Hitem 27 Is marked oft Be Samuel Scofield Ada May Hoyt ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Scofield/wife 150 North Ridge Run Manchester Center, VI 05255 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages to Department of Hamportent: if ite any injury or ot once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory 02/28/09 Odenton, MD Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 21. Signature of Funeral Service Licenses 23a. Part I. Enter the disasse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death mmediate Cause (Final Physician a Dementia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** b Failure to Thrive Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence of Examiner The law requires that the death certificate be executed use as the burial-fransi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, aftending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 should be 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? has page certificafe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2X No or Attending Physicien: rector, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2XXIo Certification: To funeral dir fhis 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1X Natural 5 Pending s affer death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide filled within 24 hours To the Funerel 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H51280 February 27, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10110 Molecular Drive Suite 206 Rockville, MD 20850 Anushiravan Dadgar, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 03

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 1 - For State Registrar 08185 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** Joanne Elizabeth Schoberg February 26 2009 9:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 22 Kate Wagner Court Westminster Carroll 8. Date of Birth Month, Day Aug 01 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Country 1 □ M 2√2 F 66 MD Director 212-42-3942 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinism must be notified at **Funeral Director** Carroll Westminster 1 ☐ Yes 2 X No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 USA 22 Kate Wagner Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: Be Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) English Teacher Education 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marie Weyer Fdmind Bender ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Scott Schoberg/son 22 Kate Wagner Court Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 3/2/2009 Hampstead, MD Carroll Cremation, Inc. 4 ☐ Donation 5 ☐ Other (Specify) ob Funeral Service Licensee Privites Funeration Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause of e Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Yea 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 3 Probably 4 Unknown funeral director, page 2 should Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate Division of Vital 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

completely filled in by the e Funeral I within 2 WJL 10

> State Registrar

(Check only one)

29b. Signature and title of certifig

31. Date filed (Month, Day,

30. Name and address of person who co

FEB

eted cause of death (Item 23a) (Type, Print)

32. Registrar's

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend Ttem 23a per phys. 6890 4 3/09 dk
State of Maryland / Department of Health and Mental Hygiene 200 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 4:25 February20,2009 /Medical Town, or Location of Death 4c. County of Death 4b., City, Facility Name (If not institution street and number) Examiner Berlin Nursingard KehabilHaion Lento 5. Social Security Number f Under i Year Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Months Days Hours Min 1 M 2 F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show ortant; If item 27 is marked other than "natural", or items 23a or 28a-f shot Injury or other traumatic event, it s. Medical Examinar must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 21813 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married SMITH, MYRA Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiers important; if Item 27 is marked other than any injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) Be ၉ 19b. Mailing Address (Street and Number Jural Route Number, 2548 Morris Rd. Bishopuill. Husband City or Town Informant's Name/Relationship (Type. Print) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 3 Removal from State N⊒Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disc shock, or heart fails HRONIC Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of) Hypertension /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) o 9 Unknown ₫. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 1 ☐ Yes 21\(\overline{2}\)\(\overline{1}\) director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1∐ Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manacr of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number OM 6/4 EAM 32. Registrar's Signature State

Registrar

LUNCE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 25 Month **Physician** antora rebruar HiaM /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner ambridge Dorchester General orchester If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 6. Sex-7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 1 M 2 □ F 66-28 Maryland Director ept. 16 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State is marked other than "natural", or items 23a or 28a-f sho raumatic event, the Medical Exaninar must be notified at 1 Ves 2 No Completed by Funeral Director ichae 10f. Zip Code al filed within 72 hours after death with the 10g. Citizen of What Country? 10e. Street and Number 66 ar 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ■ Never Married 2 Married 1 ☐ Yes 2 1 No Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Naterman Deatood 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be and Mental Pages 1 and 2 should be Stanforo ine ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Washington St. Important: If item 27 is any injury or other training once. ambridge, MD: Health neKa 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ard's Men. Park Easton 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
HENRY FUNCERO
510 Washingt 21. Signature of Funeral Service Licensee Home, nelle Ci MD,21613 washington 23a. Patri. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or is a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 2 Fetal death 3 🗆 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 I Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? Were autopsy findings available prior to completion of cause of death? certificate 1 ☐ Yes 2 🗆 No 2 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1□Yes 2⊅No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 No death. 2 Accident Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Direc 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HBUB

State

Registrar

Year)

MAR 03

31. Date filed (Month, Day,

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physicia /Medic Examin

Funeral **Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evancia rated to notified a gonee.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

		For State Registrar	State of	Marylan	d / Depa <i>Cer</i>	rtment of F tificate of i	lealth D <i>eath</i>	and Me		ne2009	08188
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/Medic	al	Pauline Nancy 4a. Facility Name (If not instituti		nber)		4b. City, Town, or	Location		ebruary	4c. County of Dea	
xamin		Chesapeake Woo	ds Center			Cambridg				Dorchest	
neral ector		5. Social Security Number 044-05-5579	6. Sex 1 □ M 2 🛣 F	7. Age <i>(In yrs. I</i> 90	ast birthday) Yrs.	If Under 1 Year Months Days	Hours	Min. A	Date of Birth (Month, Day,) ug. 14,	ear) (irthplace (State or Foreign Country) Inecticut
		Usual Residence of Decedent 10a, State 10b. Count		10c City	, Town or Lo	cation					10d. Inside City Limits
f shov	to	Maryland Dorch	•	1	Cambri						1X Yes 2 No
or 28a	Direc	10e. Street and Number				10f. Zip Code	<u> </u>		10g	. Citizen of What C	
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al", or item	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Ma 3 ☒ Widowed 4 □ Divorce	Armed For 1 ☐ Yes If Yes Giv	ces? 2 [X]No e		fYes, specify Cuba I∐Yes 2 X No	an, Mexica Specif	an, Puerto Ric	an, etc.)	Black, Wh	
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ther th	Cor	12 17. Father's Name (First, Middle	e. Last)		Secre	tary	18. Moti	ner's Name (F	First, Middle, Ma	iden Surname)	Ompany
rked o	To Be	Paul Mockovak	· · ·				Aı	nna Bel	Lorit		
is ma rauma		19a. Informant's Name/Relation Nancy Towne/Da								City or Town, State,	and 21613
Item 2		20a. Method of Disposition		20b. P		sition (Name of matory or other place		Date		c. Location - City o	
ant: If ury or		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other		state	natory o	of Delmarva	ı	2/25/2	009 D	elmar, De	elaware
any in		21. Signature of Funeral Service	1	ller	Ze		eral tree	Home, East	: New Ma	irket, MD	21631
sician		23a, Part 1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final	et only one cause on as	ach line					espiratory arres	t,	Approximate Interval Between Onset and Death
edical		disease or condition resulting in death)	a, Due to (or as a conseq	uence of):	Demen,					1/2
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cate has b page 2 sh	Completed								24a. Was an autopsy perform 1 □ Yes 2	prior to	autopsy findings available o completion of cause of ? es
certific rector,	Be	25. Was case referred to medic examiner?	Hospital:		ED/0. + -#:-	- a - Oti			Check only one,	ce 6 □ Other <i>(S)</i>	
After this funeral di	tion: To	1 Yes 2 166 27. Manner of Death 1 Atural 5 Pen 2 Accident inve	28a. Date	Inpatient 2 of Injury th, Day, Year)	28b. Time of Injury	f 28c. Inju Wo	rv at	28		injury occurred	респу)
I Director d in by the	Certification:	3 Suicide 6 Cou	ld not be 28e. Place	of Injury - At heng, etc. (Special	ome, farm, sti	reet, factory, office		28	f. Location (Stre City or Town,		Rural Route Number,
e Funera letely fille	Medical C	29a. Certifier Certific (Check only one)	ying Physician: To the al Examiner: On the b	e best of my kno easis of examina ner stated.	owledge, dea ation and/or in	th occurred at the to	ime, date opinion, d	and place, ar eath occurred	nd due to the ca I at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
To the	Me	29b. Signature and title of certi	fier lay	MA		29c. Licen	se numbe	r	29	d. Date signed (Mo	nth, Day, Year)
		30. Name and address of name	on who completed cours	se of death (Ito	n 23a) /Tuno	Print)	179	24		2-25	0 4
		30. Name and address of pers NOMAN 7/ 31. Date filed (Month, Day Ya	HANNY	503	BYRN	ST C	AMA	2116	U M	10 216	13
Sta Regist	ate rar	31. Date filed (Month, Day, Ye	2 6 2009 32. F	legistrar's Signa	ature	parked		•			

al Exami		1. Decedent's Name (First, Middle,Last) Willie Edward Stewart	-: *	Date of Death Month Da February 25,	y 2009 Year	3. Time of Death) 1 0715 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Cheverly	1	4c. County of De Prince Geo	
		Prince Georges Hospital Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth(N		Birthplace (State or
Funeral Director		223-68-1719 1XM 2 F 61	Yrs. Months Days Hours Min	July 9,		reign Country) Virginia
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rith the Maryland s 23a or 28a-f show a notified at once.	Director	10e. Street and Number 121 - 58th Street, SE	10f. Zip Code 20019		Citizen of What C Inited Si	
eath with items 23; ust be no	Funeral		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto		14. Race - Ar White, et	
ırs after di tural", or aminer m	d by Fu	3 Widowed 4 Divorced If Yes, Give Year of Dates: 15 Decedent's Education (Specify only highest grade completed) 1 16a, Dece	Yes 2 X No specify: dent's Usual Occupation (Give kind of		Specify:	Black ess/industry
hin 72 hou e. than "na! edical Exs	Completed		g most of working life. DO NOT use rei s Department Sto Emplovee	re	Priva	ate
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other trauntatic event, the Medical Examiner must be notified at once.	Be Con	17. Father's Name (First, Middle, Last) James Stewart	18.Mother's Nam Marga	e (First, Middle, Maio aret Hill		
2 should be and Mer 27 is mar	10	Christine Y. Stewart - Wife 121	iling Address (Street and Number or - 58th Street, SE	E Washingt	on, DC	20019
ges I and t of Healt : If item		1 X Burial 2 Cremation 3 Removal from State crematory o	position (Name of cemetery, rother place)		0c. Location - Cit	1
epartmen nportant ijury or o		2 Signature of Funeral Service Licensee 2	ocoln Cemetery Ma 2. Name and Address of Facility St 4001 Benning Road,	ewart Fur	neral Ho	me, Inc.
hysician Medical xaminer	Ø. 3	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Disease			Between Onset and Death
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the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. The thin scartificate has been signed by the attending physician and the Funeral Director. After this certificate has been signed by the attending physician and neelev filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): Due to (or as	Other (Specify) 26.Place of Death (Chectient 3 DOA Other; of Injury 28c. Injury at Work? 1 Yes 2 No street, factory, office building, etc.	23e. Did toba 1 Yes 24a. Was an autopsy perform 1 Yes 2 k only one) sing Home 5 Re 28d. Describe how 28f. Location (Stror Town, Sta	Month 2 No 3 24b. We price dear No 1 we injury occurred eet and Number te)	Day Year te to the cause of death? Probably 4 Unknown re autopsy findings available or to completion of cause of th? Yes 2 No Other:
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical Certification: To Be Completed by Physician/Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): Due to (or as	Other (Specify) 26.Place of Death (Chectient 3 DOA Other; of Injury 28c. Injury at Work? 1 Yes 2 No street, factory, office building, etc.	23e. Did toba 1 Yes 24a. Was an autopsy perform 1 Yes 2 k only one) sing Home 5 Re 28d. Describe hor 28f. Location (Str or Town, Sta	Month 2 No 3 24b. We prior dea 1 esidence 6 winjury occurred eet and Number te) s) and manner as and place, and due	Day Year te to the cause of death? Probably 4 Unknown re autopsy findings available or to completion of cause of tth? Yes 2 No Other: or Rural Route Number, City s stated. to the cause(s) (Month, Day, Year)

DHMH 17 Rev 1/2001 OCME 2006

1. Decedent's Name (First, Middle, Last) BADRELDIN 4a. Facility Name (If not institution, give street and number) 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Decedent 4b. City, Town, or Location of Decedent 4c. City, Town, or Location of Decedent	Prince George
Funeral Director 212-29-5478 15M 20 F 68 Yrs.	Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State of Foreign Country)
Usual Residence of Decedent	
	10d. Inside City Limits 1 ™Yes 2 □ No 10g. Citizen of What Country?
	- 0 2.
1 Never Married 2 Married 1 Yes 2 No ff Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No ff Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No ff Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: 1 Specify only highest grade completed) 1 Never Married 2 Married 1 Yes 2 No Specify: 1 Specify: 1 O No Specify: 1	D.
18. Mother's Name (First, Middle, Last)	Education Name (First, Middle, Maiden Sumame) ATIMA
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Line 19b) 19c. Mc HAMED SHAMAM (So'n Line 19b) 20a. Method of Disposition 20b. Place of Disposition (Name of	The Paral Route Number, City or Town, State, Zip Code) The Rural Route Number, City or Town, State, Zip Code) Date 20c. Location - City own, State
1 District 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	2/27/09 Stafford VA. Aden Muslim Funeral LEasy St. Woodbridge VA.
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as call shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	
Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last b. Acute rend failur Due to (or as a consequence of): Polymerolist Septic Due to (or as a consequence of): Bilateral Reumoni	
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy	23d. Date of delivery Month Day Year
v = 5.0 A	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
The law page 2 sign has been been been been been been been bee	24a. Was an autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ▼No Death Check only one
1 Yes 200 No 1 Inpatient 2 DER/Outpatient 3 DOA 4 Nursing Nursing 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	ng Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred
To the field of th	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number	place, and due to the cause(s) and manner as stated. occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
Musician D2757	7 02/25/04
30. Name and address of person who completed cause of death (filem 23a) (Type, Print) OPHNELL CUMBERBATCH, 3001, HOSPITAL DR State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature ARR 0 3 2009 Chicago A. Aparll	CHEVERLY MD. 20785

DHMH 17 Rev 1/2001

		•	For State Registrar	Sta	te of Ma	aryland / Dep <i>Ce</i>	artment of ertificate o	Health <i>f Death</i>	and Mer		iene200	9 08191
	Physicia	an	1. Decedent's Name (First, A		_					Date of Deat Month	h Day Ye	3. Time of Death
-	/Medic		Josephine	B.		Sherv	T -			03	08 200	
	Examin	er	4a. Facility Name (If not insti	tution, give street a RADDOCK (,		4b. City, Town		of Death		4c. County of D	
	Funeral		5. Social Security Number	6. Sex	7. Age	e (In yrs. last birthday) If Under 1 Ye	ar If Under	24 Hrs. 8.	Date of Birth	ALLEGAN 9.	Birthplace (State or Foreign
	Director		323-03-7046		7₹	93 Yrs.	Months Day	/s Hours	Min.	Sep 2	9, 1915	^{Country)} Illinois
	and		Usual Residence of Deceder 10a. State 10b. Co	_		10c. City, Town or I	ocation.					10d. Inside City Limits
	Maryl	tor	MD	Allegany		Fr	ostburg					1 □¥yes 2 □ No
	h the	Director	10e. Street and Number				10f. Zip Cod	e		1	0g. Citizen of What	Country?
	72 hours after death with the Maryland natural", or items 23a or 28a-f show deal Eva. Inc. rust be nottled at	ral	One Kaylor	Circle					532			SA
	er des items	Funeral	11. Marital Status	12. Was	s Decedent E red Forces? Yes 2 ☐ N	Ever in U.S. 13	. Was Decedent of If Yes, specify C	of Hispanic Or uban, Mexica	rigin? (Specify n, Puerto Rica	Yes or No- an, etc.)		American Indian, /hite, etc.
36	Ir, or	by F	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Divo	If Ye	es, Give ar or Dates:	ww II	1 ☐ Yes 2 ☐ N	Specify	•		Specify:	white
21215-0036	2 hou natura ical E	ted	15. Dec	edent's Education lighest grade comp	latad)	16a. Dec	edent's Usual Oc	cupation	st of working		16b. Kind of Busine	ess/Industry
21	within iene.	Completed	Elementary/Secondary (0-		lege (1-4or 5	+)	e kind of work do DO NOT use rei	ired)			Oueker	Oats Co.
2	iiled w Hygie ther t		17. Father's Name (First, Mid	ddle. Last)		Cle	IK	18. Moth	er's Name (Fi	rst, Middle, N	Maiden Surname)	Cais Co.
lan	ld be i ental ked o ic eve	To Be	Joseph E						vy Med	dlin Be	st	
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "Actal Economic Last be notified at	-	19a. Informant's Name/Rela		nt)	ughter 1	ling Address (Stre 8323 Ma	eet and Numb	er or Rural Ro	oute Number	r, City or Town, Sta	te, Zip Code) MD 21557
	1 and 2 Health em 27 i		Jo Frances	- King	uai		_	<u> </u>	Date		20c. Location - City	
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		20a. Method of Disposition 1 □ Burial 2 □ Crema 4 □ Donation 5 □ Oth		from State	20b. Place of Disportery, cr Restlawn	Memorial	o _{lace)} Gardens		/12/2009	LaVale	
altir	permit. F Departm Importar any injur		21. Signature of Funeral Ser	A /	Λ	<u> </u>	22. Name and Ad	dress of Facil	ity Peral Hom	ne PA		
ä	permi Depar Impor any ir		1//1		///	'	108	Virginia .	Avenue: (Cumberla	and, MD 2150	02
			23a. Part 1. Enter the discordance of the control o	e, or com: lica ions List only one aud	e on each lin	the death. Do not e ne.	nter the mode of	dying, such as	s cardiac or re	spiratory arr	est,	Approximate Interval Between Onset and Death
in the	Physician /Medical		Immediate Cause (Final disease or condit in resulting in deat)	a		psis						13 days
	Examiner		(ue to (or as	consequence of):						
	EHE!	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or nijury that initiated events resulting in death) Last	b	ue to (or as	a consequence of):						
	ecutec .nd transit	Examiner	Cause (Disease of Injury that initiated events	C								
30,	rificate be executed ng physician and as the burial-transit		resulting in death) Last		ue to (or as	a consequence of):						
68760,	physicate I	edical		d								
Вох	eath certifi attending for use as		IF FEMALE: 23b. Was decedent pregnar			of pregnancy					23d. Date of	delivery
Ä	death e atte d for u	iciai	in the past 12 months?	4 5	Pregnant a		☐ Ectopic pregn ☐ Other (specify				Month	Day Year
P.0	that the dened by the detached	Physician/M	9 ☐ Unknown		Unknown							
က်	res tha signed be det	þ	Part II. Other significant co		ig to death bi	ut not resulting in the	underlying cause	given in Part	1.		bacco use contribut es 2 □ No 3 □	te to the cause of death? Probably 4 Canknown
Records,	w requir been s should	Completed	COLONET	()	1)100	aait	THE R		- 1	m		
Rec	ne law e has ge 2 s	ld m	Divertio		and	uans	w, nai	7		24a. Was a autops perforr	sy prior	e autopsy findings available to completion of cause of h?
ta	ysician; The is certificate hidirector, page		25. Was case referred to me	Infecti	m ·			26 Plac	e of Death (C			Yes 2□No
of Vital	hysicia this cer al direct	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital	1 npatie	ent 2 ER/Outpat	ent 3 DOA	Othor:			ence 6 ☐ Other (Specify)
O L	ding Ph h. After th funeral	no:	27. Manner of Death	28a ending	. Date of Inju (Month, Da		of 28c. I	njury at Vork?	28d	. Describe ho	ow injury occurred	
Sio	tendi leath. tor: A	cati	2 ☐ Accident in	vestigation	Disease of lies			I□Yes 2□		Landing (O		5 18 1 1 1
Division	l or Al after c Direc	Certification:		etermined 28e	building, etc	ury - At home, farm, s c. (Specify)	street, factory, only	ce	281.	City or Town		r Rural Route Number,
_	spital hours neral y fillec					of my knowledge, de						
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Med one)		n the basis o d manner sta	f examination and/or ated.			ain occurred			
_	Vith Voit	Σ	29b. Signature and title of ce	ertifier			29c. Lic	ense number		2	9d. Date signed (M	Ionth, Day, Year)
				lend	/		De	7124	4		3/9/.	2009
			30. Name and address of pe		d cause of d	eath (Item 23a) (Type	e, Print	2 Jun	C N.	N A	150	

State Registrar

31. Date filed (Month, Day, Year)
MAR 1 6 2009

DHMH 17 Rev 1/2001

			1 - State Registrar	,	Cei	rtificate of I	Death	R	eg. No.	00172
			Decedent's Name (First, Middle, La.	st)				2. Date of Deat	th	3. Time of Death
	Physici		Margaret Eli	zabeth Tal	bott			Month Februar	v 27 200	
1	/Medio Examin		4a. Facility Name (If not institution, giv		<i>5000</i>	4b. City, Town, or	Location of Deat		4c. County of De	
			214 E. Sixth Str	eet		Free	derick		Frede	rick
	Funeral		Social Security Number 6. S		rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day,	Year) 9. B	Birthplace (State or Foreign Country)
	Director		213-16-12/9	□ M 213 F 9	6 Yrs.		, , , , , , , , , , , , , , , , , , , ,	April 22	2, 1912 N	Marýland
	pu "		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Lo	cation			<u> </u>	10d. Inside City Limits
	aryla shor	5	Ĺ							1 ⊠Yes 2 □ No
	he M	Director	Maryland Freder:	ick	Fre	derick 10f. Zip Code		T	0 021	
	with t	ä	10e. Street and Number			,		'	0g. Citizen of What (
	s 23	era	214 E. sixth Str	eet 12. Was Decedent Ever in	110 110		1701	Pagifu Van or No	United S	tates nerican Indian,
	item item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☒ No	10.3.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)	Black, Wh	nite, etc.
21215-0036	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be profilled at	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2 X No	Specify:		Specify:	White
9-0	2 hou	Completed	15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occup	ation		16b. Kind of Busines	ss/Industry
215	hin 7. e. an "n Medi	ple	(Specify only highest gra	College (1-4or 5+)	life.	kind of work done on the common work done of the common work with the common work and the common work done of the common work	during most of wol d)	rking		
21	d with	ĕ	7		Sea	mstress_			Leather	Goods
pu	al Hy al Hy foth	Be (17. Father's Name (First, Middle, Last,	1			18. Mother's Nar	me (First, Middle, N	Maiden Surname)	
yla	Ment Ment arked attc e	ဂ္	Unknown				Juloa '	Virginia	Marsden	
Maryland	2 should be filed within n and Mental Hygiene. Is marked other than raumatic event, Ire M		19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street	and Number or Ri	ural Route Number	; City or Town, State	, Zip Code)
	1 and 2 Health em 27 I		Shirley Remsberg/			Evergreen				rolina 27292
Ore	Jes 1 Tof H if itel		20a. Method of Disposition 1∑Burial 2 ☐ Cremation 3 ☐	Removal from State	 b. Place of Dispo cemetery, crer 	sition (Name of natory or other plac	e) Mar	ch 2,	20c. Location - City of	or Town, State
Ē	Pag ment ant:		4 Donation 5 □ Other (Specif		it. Oliv	et Cemete	ry 2	009 1	Frederick,	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, it is Notical Examinet must be notified at once.		21. Signature of Funeral Service Licer	r se e	22	2. Name and Addres	ss of Facility St	tauffer F	uneral Ho	mes, P.A.
	20 E # 9			Juta	16	21 Opossi	umtown P	ike Fred	erick, Ma	ryland 21702
			23a. Part 1. Enter the diseas com shock, or heart failure. List only	plications that caused the d one cause on each line.	eath. Do not ent	er the mode of dyin	ng, such as cardia	c or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	ASCVD						Offset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):					
	Examiner	<u>.</u>	Sequentially list conditions,	Renal Fa						
	ted	i	Sequentially list conditions, if any, leading to immediate cause. End of User, ing Cause (Disease or injury	Due to (or as a cons	sequence oi).					
	and al-trar	Examiner	that initiated events resulting in death) Last	cDue to (or as a cons	sequence of):					
68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit									
987	ficate p physis the	Medical		· 0.						
X	nding use a	_	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre	gnancy				23d. Date of c	delivery
. Bo	death e atte d for	icia	in the past 12 months? 1 □Yes 2 ☒No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time	etal death 3 L of death 5 [Ectopic pregnanc Other (specify)	у		Month	Day Year
P.0	at the de by the tached	Physician	9 ☐ Unknown	9 🗆 Unknown						
'n.	res tha signed be det		Part II. Other significant conditions of	ontributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
Ď	w require been sign should b	edk						1 □ Ye	es 2⊠No 3□	Probably 4 Unknown
၁၃	e faw requ has been e 2 should	Completed by						24a. Was ar	n 24b. Were	autopsy findings available o completion of cause of
œ	The laste has page	E O						autops perform	ned? death	es 2 🖾 No
ita	siclan: The certificate rector, pag	Be C	25. Was case referred to medical examiner?			-	26. Place of Dea	ath (Check only one		
of Vital Records,	Physic this ce al dire		1 Yes 2 XNo	Hospital: 1 ☐ Inpatient 2	⊇ ☐ ER/Outpatier	nt 3 □ DOA Oth	er: 4 🗆 Nursing H	łome 5 🔀 Reside	ence 6 ☐ Other (Si	pecify)
u u	ng ffe	ü	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year	r) 28b. Time of Injury	Worl	y at </th <th>28d. Describe ho</th> <th>w injury occurred</th> <th></th>	28d. Describe ho	w injury occurred	
sio	Attendi death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be	a			Yes 2 □ No			
Division	or At fter d Sirect in by	Certification: To	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	it home, farm, str ecify)	eet, factory, office		28f. Location (St. City or Town	reet and Number or . n, State)	Rural Route Number,
	pital urs a eral C		29a. Certifier 1 X Certifying Ph	usaleien. To the heat of my	Leanula dea daet	a aggrunned at the attention		a and due to the a	(a) and manage	
	the Hospital or Attending hin 24 hours after death. the Funeral Director: After mpletely filled in by the funer	Medical		nysician: To the best of my niner: On the basis of exam and manner stated.	nination and/or in	vestigation, in my o	pinion, death occi	e, and due to the caurred at the time, da	ause(s) and manner ate and place, and d	ue to the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Me	29b. Signature and title of certifier	/1		29c. Licens	e number	25	9d. Date signed (Mo	nth, Day, Year)
	FSFO		the de Or	L. L.		R069	310	2	3/2/09	
	(in)		30. Name and address of person who	completed cause of death (Item 23a) (Type		-			
	(0)		LINDA CRUM MUET	,			Frederi	ck, Marvl	land 21702	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Si				· y -		
	Registr	ar	MAR 032	UUS Linesum	p. 19	arked				

€ 2

15001 Dufief Mill Rd. North Potomac, MD 20878 Daniel Snow, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature, parked 2009

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

29b. Signature and title of certifier

State

Registrar

29c. License number

D45533

29d. Date signed (Month, Day, Year)

March 2, 2009

DHMH 17 Rev 1/2001

			State of Maryland / Department	artment of Health and N rtificate of Death		ne No. 2009	08195
	Physici:		1. Decedent's Name <i>(First, Middle, Last)</i> Dale Edmund Townsend			Day Year	3. Time of Death
1	/Medic Examin		4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTY	4b. City, Town, or Location of Death SAUS bucy	,	4c. County of Death	100
	Funeral Director		5. Social Security Number 222–22–6638 6. Sex 7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 10-05-193		lace (State or Foreign try) Jare
	h the Maryland or 28a-f show	Director	Usual Residence of Decedent		10g.	Citizen of What Coun	0d. Inside City Limits 1 XYes 2 □ No try?
336	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Everninger rugt be muthed at	by Funeral [1 Never Married 2 Married 1 TYes 2 XNo	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	USA 14. Race - Americ Black, White, & Specify:	
21215-0036	ed within 72 hou ygiene. her than "natura t, the Wedest Et,	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+) 5 none	dent's Usual Occupation kind of work done during most of work DO NOT use retired) Waller	ing D:	. Kind of Business/Ind	dustry
Maryland 21	hould be filed of Mental Hygistrarked other marked other matic event, I	To Be	17. Father's Name (<i>First, Middle, Last</i>) Frank V. Townsend 19a. Informant's Name/Relationship (<i>Type. Print</i>) 19b. Maili	18. Mother's Nam Elizabet ng Address (Street and Number or Ru			Code
ore, Ma	permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If item 27 is marked other ta any Injury or other traumatic event, Insonce.		Joan Townsend/wife 3061. 20a. Method of Disposition 1 □ Burial 2 Cremation 3 □ Removal from State 220.	2 Antioch Ave., Prosition (Name of matory or other place)	incess An	ne, MD 218 Location - City or To	53
Baltimore,	permit. Page Departmen Important; any injury once.		4 □ Donation 5 □ Other (Specify) Sallsbur 21. signature of Funeral Service Licensee H	y Crematory 102/28 2 Name and Address of Facility Inman Funeral Home 1673 Somerset Ave.	72003	lisbury, M	J
ı	Physician /Medical	0	21a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			s Ame, Tu	Approximate Interval Between Onset and Death
	certificate be executed XX anding physician and XX ise as the burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):				
O. Box 687	certific ding p	Physician/Medical		□ Ectopic pregnancy □ Other (specify)		23d. Date of delive	ery Day Year
rds, P.	The law requires that the death ate has been signed by the atter age 2 should be detached for u	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the	
		Completed			24a. Was an autopsy performed 1 ☐ Yes 2 ☐	? prior to condeath?	psy findings available mpletion of cause of 2 No
Vita	siciar s certif	Be c	25. Was case referred to medical exampler? 1 ☑ Yes 2 ☐ No Hospital: 1 ☐ Uppatient 2 ☐ ER/Outpatie	Othori	th (Check only one)	e 6 □Other (Specif	- 4
Division of	or Attending Physician; ifter death. Director: After this certifici in by the funeral director.	Certification: To	27. Manner Death 1 atural 5 Pending investigation 28a. Date of Injury (Month, Day, Year) Injury		28d. Describe how in		y)
Divis	oital or Atter de urs after de vral Directo		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		City or Town, Si		<u> </u>
	To the Hospital or , within 24 hours after To the Funeral Dire completely filled in E	Medical	29a. Certifier (Check only one) 1 □ Certifying Physician: To the best of my knowledge, dea (2 □ Medicai Examiner: On the basis of examination and/or i and manner stated.		rred at the time, date		the cause(s)
),	TJ		30. Name and address of person who completed cause of death (Item 23a) (Type	D5-542	7	2/26	ful
	Sta		Christian Bounds, M.D. P.R. 1 31. Date filed (Month, Day, Year) 32. Registrar's Signature	M.C. 200 E. Car	roll St	Salisburg	MD &1801
	Regist	rar	NAR 0 3 2009 Zenna 1.	Sall			

DHMH 17 Rev 1/2001

ORIGINAL

09-01936			pe or Print in B								gible	.	
Jerry Lee Timmons		S For State	tate of Maryland	•	rtment (tificate (d Menta	al Hygie	ene		200	19 0819
Physician/	R	egistrar . Decedent's Name (First, Midd	die,Last)		uncate (oi Deal			2. D	Re ate of Deat	eg. No. th		3. Time of Death
Medical Examine	-	Jerry Le		S					M	onth arch 8, 2	Day 2009	Year	0902 hrs
	4	la. Facility Name (if not instituti 25471 Ocean Gatewa	-	r)		4b. City, Salisl		Location of	Death _.			. County of Dea Vicomico	ith
Funeral		Social Security Number	6. Sex 7. A	ge (In yrs. la	ıst birthday)		er 1 Year		_	Date of Birt	th(MM/	DD/YYYY) 9. E	Sirthplace (State or
Director	L	216-40-4074	1_ X M 2_F	66	Υ	rs. Month	s Days	Hours	Min.	10/15	/19	42	De Yaware
any	_	Jsual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation	_						10d. Inside City Limits
<u> </u>	5	Maryland Wid	comico	5	Salisb	ury							1 X Yes 2 No
Baltimore, MD 21215-0036 Permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiens 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Re Compileted by Funeral Director		0e. Street and Number 123 Lakewood	Drive			10f. Zip 2.	1804			10	0g. Citi:	zen of What Co USA	ountry?
r death with or items 23. must be no	e la	1. Marital Status	12. Was Deceder			Vas Decede Yes, speci					-	14. Race - Ame White, etc.	erican Indian, Black,
r death	5	1 Never Married 2 X N	1 X Yes	2 No		_	-		0011071100	,,,, 0.0.,			hite
nrs afte	<u></u> ≧⊦	3 Widowed 4 Di 15. Decedent's Education (Spe	vorced If Yes, Give Year A. cr Dates: ecify only highest grade co		16a. Deced			specify: on (Give kir	nd of work	done	16b. F	Specify: V Kind of Busines:	
1036 within 72 hours ene. er than "natun Medical Exam		Elementary/Secondary (0-12				most of wo					• •		
5-0036 lifed within 72 Hygiene. I other than the Medical Comple		12	_		rout	e sal						nifirst	Corp
filed w Hygie d othe	3	7. Father's Name (First, Middle Alton Timmons	. ,				1	l8.Mother's	,		Maiden	Surname)	
2121 ould be fil d Mental Is s marked lic event,	0	9a. Informant's Name/Relation			19b. Mail	ing Address	Street		na Lav		nber, Ci	ity or Town, Sta	te, Zip Code)
MD d 2 shot lith and lung 17 is numatic	1	Patsy Timmor				•	,					4D 2180	
re, h l and Health Fitem		20a. Method of Disposition	0 🗆 🗈		Place of Disp				Da	te	20c. l	Location - City	or Town, State
More, Pages I an hent of He ant: If ite		1 X Burial 2 Crematic 4 Donation 5 Other S		Spare Spare	rematory or ringh arden	S			3/13,			Hebron,	
Balti permit Departm Imports injury o		21 Signature of Euneral Serv			22	Name and	Address	of Facility	al Ho	me Pr	ofe	ssional	Association
	1	23a. Part I. Enter the disease, of	VIVI-	od the death		DOT 5	now	HITT	Ra.,	Salis	sour	V, MD Z	21804 Approximate Interval
Physician /Medical	4	failure. List only one cause	e on each line.	Athero								on, or rear	Between Onset and Death
xaminer		Immediate Cause (Final diseas or condition resulting in death)	e a. Due to (or as a con			JUIC (carui	LOVASC	Julai	uise	450		
		Sequentially list conditions,	b										
l l		f any, leading to immediate cause. Enter Underlying Cause	Due to (or as a con	sequence of	f):								
ed nsit Fxaminer	Xal	(Disease or injury that initiated events resulting in death) Last	Company from the land of	sequence of).								
e executed ian and ial - transit	- g	X UNPENDED	d. AMENDED 23	3a,27,	perME	, g889	3/1	7/09	TT				
760, cate be physic he bur	Ĭ	F FEMALE:	23c. If yes, outc	ome of pregi	nancy						230	d. Date of delive	эгу
Division of Vital Records, P.O. Box 68760, within 24 hours are detected by P.O. Box 68760, within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transfording Contification. To Re Completed by Physician/Medical Endical Endication.	ician/	3b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 Ur	4 Pregnant	at time of de	oth -	Fetal death Other (Spe		Ectopic	pregnancy			Month	Day Year
the der	ξŀ	Part II. Other significant cond	9 Unknown	ath but not re	esulting in th	e underlying	cause o	iven in Part	H.	23e, Did to	bacco	use contribute	to the cause of death?
P.O. es that the igned by be detach	2						, 3			1 Yes	2	No 3 Pr	obably 4 🗸 Unknown
rds, requir										24a. Was autop			autopsy findings available o completion of cause of
Records, The law require: ficate has been sign, page 2 should be											rmed?	death'	
Vital Rec ysician: The his certificate director, page		25. Was case referred to medic examiner?						of Death (C	Check only	one)			
of Viting Physici and Physician	٥L	1 ✓ Yes 2 No		tient 2	ER/Outpatie				Nursing Ho			ence 6 🗸 Oth	ner: Scene
Division of Vital Records, tall or Attending Physician: The law requirant and abrendent. In Director: After this certificate has been seled in by the funeral director, page 2 should be artification: To Re Commisters.		27. Manner of Death 1 X Natural 5 Per	28a. Date of Ir (Month, Day	njury (,Year)	28b. Time o	of Injury		ryat Work? ′es 21	- 1	. Describe I	how inji	ury occurred	
risior r Attend ter death irector: n by the	<u> </u>	2 Accident Inve	estigation 28e. Place of	Injury - At ho	ome, farm, st	reet, factory			_			and Number or I	Rural Route Number, City
Divis			ermined (Specify)							or Town, S	State)		
Divisior Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the			Physician: To the best of										
To the Hos within 24 h To the Fur completely			aminer: On the basis of ex and manner state		nd/or investi				urred at the	time, date			
2	-	29b. Signature and title of certif	N. ns	5		29	c. License O.C.N					ch 9, 2009	fonth, Day, Year)
	-	30. Name and address of perso	on who completed cause of	death (Item	23a)		2.0.1						
			ant Medical Examin		Penn Str	eet, Balti	more, I	MD 2120)1				
Stat Registra		31. Date filed (Month, Day, Year	1 0000 //	rar's Signatu	To A	arkal	,					•	

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Division of Vital Records, P.O. Box 68760,

		For State	State o	f Marylan	d / Depa	artmen	t of He	ealth an	d Menta	l Hygie	ene 2	nna	n s I	97
		State Registrar 1. Decedent's Name (First, Min			Ce	rtificate	e ot D	eatn		Reg e of Death	. No. —	007	3. Time of Dea	ath.
Physici		Richard	Jule, Last)	W.		Towns	and		Mo	nth	Day 25	Year 2009	18234	2 M
/Medic Examin		4a. Facility Name (If not instity	tion, give street and nur					ocation of D				nty of Death	1000	
		Kninsula Ke	Georal Mea			5	alisb	Uly				Icomi		
Funeral Director		5. Social Security Number 212-72-1008	0. Sex 1 M 2 □ F	7. Age (In yrs. 57	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 I Hours N	Hrs. 8. Dat Min. (Mo	e of Birth onth, Day, Y -2-195	(ear)		olace (State or Fo otry) 1and	oreign
land ow		Usual Residence of Decedent 10a. State 10b. Cour	nty	10c. Cit	y, Town or Lo	ocation						1	0d. Inside City L	imits
Mary I-f sh	tor	MD Wie	comico	P	arsons	burg							1 □ Yes 2🛣	No
or 28	Director	10e. Street and Number		1		10f. Zip	Code			100	. Citizen o	of What Cour	ntry?	
ath w		7471 Walston						849	0.40 11.14			SA		
ter de	Funeral	11, Marital Status 1 □ Never Married 2 ☑ N	Armed Fo	edent Ever in U. rces? 2 🕅 No	.5. 13.	If Yes, spec	ent of His	, Mexican, Pi	? (Specify Ye uerto Rican, e	etc.)		Race - Americ Black, White,		
ours al	þ	3 ☐ Widowed 4 ☐ Divord	If Yes, Giv	ve		1 □Yes 2	2 X)No	Specify:			Spe	cify: Whi	te	
72 hc	Completed		dent's Education shest grade completed)		(Give	dent's Usua kind of wor	k done du	ion ning most of	working	16	ib. Kind of	Business/In	dustry	
within iene. than	dwo	Elementary/Secondary (0-12	College (1	I-4or 5+)		DO NOT us ofer	e reurea)				Co	nstruc	tion	
afiled af Hyg other vent,	Be C	17. Father's Name (First, Midd	lle, Last)				1	18. Mother's	Name (First,	Middle, Ma				
ould be Menta arked arlic er	70 E	Robert	W.	T	ownser	nd]	Hilda		Bell	.e		Adkins	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hiury or other traumatic event, the Medical Eventian Function to ance.		19a. Informant's Name/Relation		Dan Dan		0			or Rural Route				,	
tem 2		Charlotte M. 1 20a. Method of Disposition	Hitchens -		Place of Dispo cemetery, crei				Date			urg, M. on - City or To	D 21849 wn, State	
Pages nent of nt: If i		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other		State	<i>emetery, crei</i> matory			i	-26-20	09 D	elma:	r, Del	aware	
permit. Departm Importa any Inju		21. Signature of Funeral Serv	ice Licensee	0.		2. Name an				s Fun				
2		Deno	Tely to	eks)	7	705 E.	Main	n Stre	et, Sa	lisbu	ry,	Maryla	nd 21804	4
Physician		23a. Part1. Enter the disease shock, or heart failure. I Immediate Cause (Final disease or condition		each line.					rdiac or respii	ratory arres	t,		Approximate Interval Betwee Onset and Dear	
/Medical Examiner		resulting in death)		(or as a conseq				·						
	ler	Sequentially list conditions, if any, leading to immediate	b. CO Due to	(or as a conseq	uence of):									
cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1 c. Ane	me	of cu	ronte	- D	sese						
icate be executed physician and s the burial-transit		resulting in death) Last	Due to	(or as a conseq	uence of):									
ficate physi	edical		d											
h certi ending use a	m/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		□ Catania a					23d.	Date of deliv	ery	
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nant at time of o		☐ Ectopic pi ☐ Other (sp						Month	Day Yea	r
that the		Part II. Other significant cond	ditions contributing to de	eath but not res	ulting in the u	ınderlying ca	ause giver	n in Part I.	23	e. Did toba	cco use c	ontribute to t	ne cause of deat	h?
quires an sign ald be	d by									1 ☐ Yes	2 🗆 No	3 □ Pro	pably 4 Unki	nown
law re as bee 2 sho	Completed								24	a. Was an autopsy	24	b. Were auto	psy findings avai	ilable e of
: The l	Сош								1 [performe	d? No	death? 1 ☐ Yes	_	0.
sician: The certificate rector, pag	Be	25. Was case referred to med examiner?	Hospital:				Other		Death (Chec					
g Physer this eral di	n: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date	of Injury	28b. Time of		8c. Injury	4 ⊔ Nursir at	ng Home 5	☐ Residen escribe how			(y)	
endin sath. or: Aft he fun	atio	Z LI Accident	estigation	nth, Day, Year)	Injury	М	Work? 1 □ Ye	es 2□No						
al or Att	Certification:		uld not be ermined 28e. Place buildi	of Injury - At he ing, etc. <i>(Specil</i>	ome, farm, st fy)	reet, factory	, office			cation (Stre y or Town,		mber or Run	al Route Number	
To the Hospital or Attending Physician: with 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical (29a. Certifier 1 Certi (Check only one) 2 Medi		pasis of examina iner stated.	ation and/or in	nvestigation	, in my op	inion, death	occurred at the	ne time, dat	e and plac	ce, and due t	o the cause(s)	
To th withir To th comp	Me	29b. Signature and title of cer	tifier			290	. License	number		290	d. Date sig	ned (Month,	Day, Year)	
12001		· WW/	Jaken	MI	<u> </u>	1	100	677	-38		3/:	05/09	· 	
Sam		30. Name and address of pers	son who completed caus	se of death (Iter	m 23a) (Type,	Print)	No	1154	Sal	Isha	NI	. תע	21801	
Sta Registi		31. Date filed (Month, Day, Ye	ear) 32. g	egistrar's Signa	ature.	Bare	,	., 0/	-4.		1	10 40° C	Day, Year)	-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 8

			for State Registrar	State of Ma	aryianu /	Cer	rtificate of	Death	Mental Hy	/gieno Reg. No	Pro	09	08198
	Physici	an	1. Decedent's Name (First, Middle, La	st)					2. Date of Do Month	eath Da	ay	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, giv	IANELA IRE	NE TOMI	IN	Ab City Town	or Location of Deat	MAR				1:50 P
	Examin	er	NATIONAL NAVA		CENTER	i	•	THESDA	n	40	. County o		MEDV
Т	Funeral		5. Social Security Number 6. S	ex 7. Age	e (In yrs. last b	irthday)	If Under 1 Year Months Days	If Under 24 Hrs		rth		9. Birthp	DMERY lace (State or Foreign
ı	Director		059-56-4961	□ M 2 Q F	48	Yrs.	Widitis Days	Hours Min.	March 2	20,	1960	Pana	ma
land	M ti		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Loc	cation					1	0d. Inside City Limits
Mary	A-f sh	tor	VA Prince V	Jilliam	Dumfri	es							1 ☐ Yes 2 No
th the	or 28;	Director	10e. Street and Number	, III I I I	Dameri		10f. Zip Code			10g. Ci	tizen of W	hat Coun	try?
ath wi	\$ 23a	ral	17316 Sligo Loop	y-			22026			U.S	.A.		
r ter de	items ner n	Funeral	11. Marital Status1 ☐ Never Married2 ☐ Married	12. Was Decedent E Armed Forces?		13. V	Vas Decedent of Yes, specify Cub	Hispanic Origin? (S ban, Mexican, Pueri	Specify Yes or Note to Rican, etc.)	0-	14. Race Black	- Americ , White, e	an Indian, etc.
G Z I Z I 3-UU36 filed within 72 hours after death with the Maryland	ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be redified at	ģ	3 ☐ Widowed 4 ☑ Divorced	1 ∏ Yes 2 ☐ N If Yes, Give Year or Dates:1	988-	1	Yes 2 ☐ No	Specify:Pan	amanian		Specify:	B1ac	k
3-0	natur Jical I	Completed	15. Decedent's Ec	fucation	007	a. Deced	ent's Usual Occu	pation		16b. K	ind of Bus	siness/Inc	fustry
Z I Z I 3-0036 d within 72 hours aff	than "	ldm	Elementary/Secondary (0-12)	College (1-4or 5	+)			during most of wor	King			_	
d A	Hygic other i		17. Father's Name (First, Middle, Last)	5+		Co	ordinato	18. Mother's Nar	ne (First, Middle		F.B.]		
g a	ital ev	To Be	Miguel E. Mendoza					Mirtila				7	
aryla should	th and Mer 7 is marke traumatic	-	19a. Informant's Name/Relationship (Type. Print)				t and Number or Ru				State, Zip	Code)
	of Health item 27 i rother tra		Mirtila Worrell -	Mother				. Brook1	yn, NY.				
	nt of H : If ite or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		20b. Place of cemete	of Dispos ery, crem	sition (Name of atory or other pla Nationa	ce)	Date		ocation - (-	
ILIT	Department of Important: If it any Injury or conce.		4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Licer		Cemete	rv		2/23/					irginia
D E	any		Det K	1 Cela				ess of Facility Mo B1vd. Da					me
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do	not ente	r the mode of dy	ing, such as cardia	c or respiratory a	arrest,	221.	/	Approximate Interval Between
Ph	ysician		Immediate Cause (Final disease or condition			OLON	CANCER					1	Onset and Death
	Medical aminer		resulting in death)	Due to (or as a	a consequence	of):							
		-	Sequentially list conditions,	b. Due to lor as a	a consequence	offi:						-	
executed	ansit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	•									
e exe	ian ar ırial-tı		resulting in death) Last	Due to (or as a	consequence	of):							
rtificate be ex	physician and the burial-transit	Medical		.d									
_ =	D 88		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy						20d Data	of dolling	
death ce	n. After this certificate has been signed by the attendir funeral director, page 2 should be detached for use	Physician/	in the past 12 months?	1 Live birth 4 Pregnant at			Ectopic pregnand Other (specify)	cy 			23d. Date Mon		Day Year
that the	by the	hys	9 Unknown	9 Unknown									
ires th	signed be de	ρ	Part II. Other significant conditions of	ontributing to death bu	it not resulting i	n the un	derlying cause gi	ven in Part I.					e cause of death?
acords, law requires t	been	eted									_		
The law	e has	Completed							24a. Was auto perfo		24b. W	ere autor ior to con eath?	osy findings available apletion of cause of
	rtificat tor, pa	BeC	25. Was case referred to medical					26. Place of Dea	1 □Yes		11	□Yes	2 □No
Ol VII.a Physician:	his ce I direc	일	examiner? 1 ∐ Yes 2 [X] No	Hospital: 1X Inpatie	nt 2 ER/O	utpatient	3 □ DOA Oti		lome 5 ☐ Resi		6 □Othe	(Specify	·)
_ 0	After t unera	ü	27. Manner of Death 1 ↑ Natural 5 Pending	28a. Date of Injur (Month, Day		Time of Injury	28c. Inju Wol	rk?	28d. Describe	how inju	y occurre	d	
l or Attending	death ctor: ,	icat	2 Accident investigation 3 Suicide 6 Could not be		ry - At home for	rm etro		Yes 2□No	28f Location /	Ctrastar	ad Alisanha	a a Comple	Davida Alverta
פֿ ב	Direct Di	Certification:	4 Homicide determined	building, etc	. (Specify)	iiii, stre	et, lactory, office		City or To	wn, State)	r or Hurai	Route Number,
lospit	within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun		29a. Certifier 157 Certifying Ph	yslcian: To the best on iner: On the basis of	of my knowledg	e, death	occurred at the t	ime, date and place	e, and due to the	cause(s) and mar	nner as st	ated.
the H	thin 24	Medical	one	and manner sta	ted.				med at the tille,				
₽ 1	2 0	-	29b. Signature and title of certifier	- MD			29c. Licens		(77.4.)		te signed		**
	n		30. Name and address of person who		eath (Item 23e)	(Tyne P	u.i.m.A\	1238746			161		1
	$\mathcal{I}_{\mathcal{O}}$		LOUIS MOYER LT	MC IISN	(nom Loa)	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	NALI	ONAL NAVA ESDA MD 2			ENTE	R	
	Sta	te	31. Date filed (Month Day, Year) WAR 16 26	32 Registra	r's Signature	1		HUUNA IIV 4	-,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
	Registra	ar	HUIL T O CO	U CERM	U 1.	100							

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2009 February Richard Arthur Winn 7:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠M 2□F Months Days Hours Director 209-12-8435 Jan. 23, 1925 Pennsylvania Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Exprainer must be notified at 1 ∏Yes 2 XINo Directo Maryland Frederick Walkersville the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30 Georgetown Road Funeral 21793 death United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Itel 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 2 1 ☐ Yes 2 ☑ No Specify: Specify 3 Midowed 4 Divorced WWII White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 5 Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 George A. Winn Rachel Noble 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other training. Brad Winn/ Son 9226 Links Road, Walkersville, Maryland 21793 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3/4/2009 1 ဩBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Memorial Gardens Frederick, Maryland 22. Name and Address of Facility
Stauffer Funeral Homes P. A. 21. Signature Anneral Service Lic 621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed burial-transi and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached for Ö 9 Hlnknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes P☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performe After this certificate 1 ☐Yes 2 ☐No 1 □Yes 2 DNo 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending F after death. Natural 5 Pending Injury investigation neral Director; / 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours Funeral Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 2170) 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAR 0 3 2009 Registrar

			_ FOI	of Maryland / De			ental Hygie	ene	00000
			State Registrar		ertificate of	Death		2009	
	Physici	an	1. Decedent's Name (First, Middle, Last)	C			2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Marion Linwood Wheatl 4a. Facility Name (If not institution, give street and n		4b. City. Town, o	r Location of Death	rebruary	27, 2009 4c. County of Death	2:50 P M
	Examin	er	Mallard Bay Care Center	,	Cambrida			Dorchest	
-	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthd	ay) If Under 1 Year Months Days	If Under 24 Hrs	8. Date of Birth	0 Dieth	place (State or Foreign intry)
ž.	Director		214-20-0137	90 Yrs	.		July 19,	1918 Mary	
	land w t		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	r Location				10d. Inside City Limits
	Mary Fishe	tor	Maryland Dorchester	Cambi	ridge				1 ☐ Yes 2 No
ζ	th the or 282 e noti	Director	10e. Street and Number		10f. Zip Code		100	g. Citizen of What Cou	intry?
3	ath wil	ral	5527 White Hall Road		21613			USA	
Maryland 21215-0036 🥒	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	Armed I	3 2 No Give 1946	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🕅 No	lispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: Whi	, etc.
200	72 ho natur lical B	Completed	15. Decedent's Education (Specify only highest grade completed	1) (G	ecedent's Usual Occup	during most of working	16	6b. Kind of Business/I	ndustry
21	rithin ne. han "l	mple	Elementary/Secondary (0-12) College	(1-4or 5+)	e. DO NOT use retired er/Operator	d)) 1 m	
2	filed w Hygie ther t		17. Father's Name (First, Middle, Last)	Owite	:I/Operator	18. Mother's Name		roduce Tru	icking
an	ld be ental ked o	To Be	Roland Linwood Wheatley			Elsie Br		,	
ary	shou and M s mar umat	-	19a. Informant's Name/Relationship (Type. Print)	19b. M	ailing Address (Street			City or Town, State, Zi	ip Code)
Σ	and 2 ealth a n 27 is		Shirley B. Wheatley/Wife					e, Marylar	
Baltimore,	ges 1 t of H If iter or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from	n State cemetery,	sposition (Name of crematory or other plac	ce)		Oc. Location - City or T	own, State
ij	t. Partmen		4 □ Donation 5 □ Other (Specify) 21. Signat le Funeral Service Urense		Market Cemet			ast New Ma	
Ba	permi Depa Impo any ii		Thornwal &					Box 207 arket, MD	
			23a. Parth. Enter the disease, or complications that shock, or heart failure. List only one cause of immediate Cause (Final	Conch line		-			Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Due t	acterial o (or as a consequence of): eviv (clim)	ENMOCE	vains			
B	Examiner		1 Art	erio (c len)	ic Cardio	volleda	difen	1	
		ner	Esqueridally fist our difference if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	o (or as a consequence of):					
	ecuted ind transi	Examine	that initiated events c.						
8760,	cate be executed physician and the burial-transit		Due t	o (or as a consequence of):					
687	icate physi s the l	dical	d		,				
O. Box	requires that the death certific een signed by the attending p nould be detached for use as	Physician/Me	in the past 12 months?	outcome pf pregnancy birth 2 ☐ Fetal death gnant at time of death known	3 □Ectopic pregnancy 5 □ Other (specify) _	у		23d. Date of deliv	very Day Year
0	quires that in signed by uld be deta	by	Part II. Other significant conditions contributing to	•	e underlying cause giv	ren in Part I.	23e. Did toba 1 □ Yes	acco use contribute to	the cause of death?
or Vital Records,	The law ate has b page 2 sl	Completed					24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐		tiont 3 DOA Oth	26. Place of Beath			
ō		. To	27. Manner of Death 28a. Dat	Inpatient 2 ER/Outpate of Injury 28b. Tim	e of 28c. Injur	4 Mursing Hor	ne 5 ∐ Residen 28d. Describe how	ce 6 □Other (Spec rinjury occurred	ify)
ion	Attending Products of the funeral date of the	atior	1 ☐ Maturat 5 ☐ Pending (Ma 2 ☐ Accident investigation	onth, Day Year) Inju		rk? Yes 2 ☐ No			
Division	i di te	Certification:	3 ☐ Suicide 6 ☐ Could not be determined bui	ce of injury - At home, farm iding, etc. <i>(Specify)</i>	, street, factory, office	2	28f. Location (Stre City or Town,	et and Number or Rui State)	ral Route Number,
	he Hospital n 24 hours a he Funeral I pletely filled	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To t 2 Medical Examiner: On the	he best of my knowledge, d basis of examination and/d anner stated.	eath occurred at the ti or investigation, in my o	me, date and place, a opinion, death occurr	and due to the cau ed at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the I within 2 To the Complet	N	29b. Signature and title of certifief	1	29c. Licens			d. Date signed (Month	, Day, Year)
	-11		Many (/	1)4.	7924		3-4-09	
	5+1		30. Name and address of person who completed ca	use of death (Item 23a) (Ty 503 ByRN Registrar's Signature	pe, Print)	AMBRIOLE	MD	21613	
	Sta Registi		31. Date filed (Month NAR = 0 4 2009 32.	Common Signature	practed				

		For State	State of Maryland /	Depart Certif	ment of Hi icate of L	lealth and I Death		giene 2009	08201
		Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Dea		3. Time of Death
Physic /Med	ical	ERIC 4a. Facility Name (If not institution, give st.			E Man	Location of Death	Februai		
Exam	iner	The Johns Hopkins Hos			Baltimore		•	40. Obdaty of Book	
Funera		5. Social Security Number 6. Sex	7. Age (In yrs. last b		f Under 1 Year lonths Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	h 9. Birt (, Year) Coo	hplace (State or Foreign untry)
Directo		Usual Residence of Decedent	44				05/26	/1964 Was	hingtonDC
//arylar f show	ō	10a. State 10b. County	10c. City, To						10d. Inside City Limits 1 Yes 2 No
th the A or 28a-	Direct	MarylandPrince Ge	eorge Spri	ngdal	e 10f. Zip-Code			10g. Citizen of What Co	untry?
eath wir	eral	3535 Edwards St	2. Was Decedent Ever in U.S.	12 Wa	207		ancifu Vac or No	USA 14. Race - Ame	rican Indian
and 21215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:		es, specify Cuba	ispanic Origin? (S in, Mexican, Puerti Specify:	Rican, etc.)	Specify:	e, etc.
5-0036 72 hours aft natural", or		15. Decedent's Educ (Specify only highest grade		(Give kin	t's Usual Occup d of work done o	during most of wor	king	16b. Kind of Business/	
2121 ed within 7 giene. er than "r the Med	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		NOT use retired ving C	,		Mckesson Pharmace	utical
e e = e	e e	17. Father's Name (First, Middle, Last)		RECEL	VIII9 C		me (First, Middle,	Maiden Surname)	<u>ucicai</u>
Baltimore, Maryland 2 permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If item 27 is marked other any lighty or other traumatic event, the market.	卢	Gary 19a. Informant's Name/Relationship (Type	Wisen		Address (Street		n Jenk	ins er, City or Town, State, Z	Zin Code)
Mal nd 2 sh alth and 27 is r		Gary & Lillian W	Parents	J	,				, ,
Ore,		20a. Method of Disposition 1 Burial 2 Cremation 3 Re	20b. Place	e of Dispositi etery, cremat	on (Name of ory or other plac	:e) ;		ale MD 20 20c. Location - City or	
altimore, rmit. Pages 1 ar partment of Hee portant: If item y injury or othe		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fulleral S → Licensee			tion_C	- III.	/09	Clinton,M	aryland
Deperment any in position		1 Llage 6	191	ı Ad	ams Fu	neral H	ome PA	Aquasco.	MD 20608
		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. Do cause on each line.	o not enter t	he mode of dyin	ng, such as cardia	or respiratory ar	rrest,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or a consequence	ce of):	*				
Examiner		Sequentially list conditions, b.	Biliary	lea	K		•		
ed sit	Examiner	if any, leading to immediate	Due to (or as a consequence Metasticat			· +6 /	- I	celenal mass	
execut execut in and irial-trai		Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequence		wire - c	200100	uige au	Cite/141 1955	
8760, icate be executed physician and s the burial-transit	edical	d.							
Box 68 death certific attending p		IF FEMALE: 23b. Was decedent pregnant 23	ic. If yes, outcome of pregnancy		otopia prograna			23d. Date of del	ivery
O. Box he death ce the attendir ched for use	Physician/M	in the past 12 months? 1 ☐ Yes 2 1 No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		ctopic pregnancy ther (specify)	y .		Month	Day Year
cords, P.O. E v requires that the de been signed by the a should be detached	þ	Part II. Other significant conditions conf	ributing to death but not resultin	ng in the und	erlying cause gi	ven in Part I.	23e. Did to	obacco use contribute to ⁄es 2 □ No 3 □ Pr	.1
D & OC	Completed						24a. Was a autop perfor		atopsy findings available completion of cause of 2 No
f Vital Roysiclan: The Bost certificate ha	Be	25. Was case referred to medical examiner?	ospital:		Othe		th (Check only or	- · · · · · · · · · · · · · · · · · · ·	
Physic Physic r this co	10	27. Magner of Death	28a. Date of Injury 28t	Outpatient b. Time of	28c. Injury	y at	ome 5 Resid	lence 6 Cother (Spec now injury occurred	cify)
Sion tending eath. or: After the fun	ertification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	Injury		Yes 2 No	006 1	Otenná anad Massahan an D	On to North a
DIVI	Certifi	4 ☐ Homicide determined	28e. Place of injury - At home, building, etc. (Specify)	iarm, street	, lactory, office		City or Tow	Street and Number or Run, State)	urai noute Number,
Division of Vita Io the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	edical		clan: To the best of my knowled er: On the basis of examination and manner stated.						
To the within To the	Me	29b. Signature and title of certifier	7/1 001	· · ·	29c. License		:	29d. Date signed (Month	n, Day, Year)
		30. Name and address of person who col	moleted causers death (Item 23	la) (Type Pri		5-000		7/73/09	
BB5		Donald Ran	Lynch Sr.	~, (iype, rπ)	600	North Wo	lfe St, Baltimo	ore, MD, 21287
S Regis	tate trar	31. Date filed (Month, Day, Year) FEB 2 7 200	32. Registrar's Signature	. pa	ike				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** 951 PM Whitehead Kevin /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center Baltmore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 € M 2 □ F Director 8/4/1976 Washington, 578-96-1025 Usual Residence of Decedent 10c. City, Town or Location the Maryland 10d. Inside City Limits 10a State 10h County 28a-f show Examiner must be notified at 1x Yes 2 □ No Director Maryland | Prince George's Temple Hills 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe death with ò items 23a 5900 Temple Hills Road 20748 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after on Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Marical Examir and any injury or other traumatic event, the Marical Examir and any injury or other traumatic event, the Marical Examir and any injury or other traumatic event, the Marical Examir and any injury or other traumatic event. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify. Specify: Black ş 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) General Clerk Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ralph Whitehead Nancy Singleton 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5900 Temple Hills Rd. Temple Hills, Maryland 20748 Nancy Whitehead / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 3/6/2009 Landover, Maryland Harmony Memorial 22. Name and Address of FacilityPope Funeral Homes, P.A. 21. Signature of Funeral Service Licensee More Some Strain Maryland 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner actoremia tinotrophomonas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (br as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Acute Lymphobiastic Leutemia and burial-tran Due to (or as a consequence of): attending physician Physician/Medical as IF FEMALE: . If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 | Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown is certificate has been signed by director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 3 Probably 4 Unknown 2 No 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Mayner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760.

24 hours after death. filled in by the within 24 hor To the Fune completely fi 5 3

Medical

29a, Certifier

(Check only

29b. Signature and title of certifier

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Baltmore

29c. License number

1548429673

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 State Registrar	Certific	ate of Death	Reg.	No.2009	08203
i.			1. Decedent's Name (First, Middle, Last)	. IV 1	3	2. Date of Death Month	Day Year	3. Time of Death
-August	Physicia /Medic		Vesta & Ha	Whit	tington	Februar	424,2009	2126
الم	Examin	er	4a. Facility Name (If not institution, give street and number)		ity, Town or Location of Death Itimore City		4c. County of Death	_
	ं ं — ं — ।			(In yrs. last birthday) If Ur	nder 1 Year If Under 24 Hrs.	8. Date of Birth	Datino: 9. Birthplace	ce (State or Foreign
ingt.	Funeral Director		219-01-3833 1 □ M 2XF Usual Residence of Decedent	99 Yrs. Mont	hs Days Hours Min.	(Month, Day, Yea	10 Phil	a, ta
	land low			10c. City, Town or Location			10d	I. Inside City Limits
	a-f sh	ctor	MD Battimore	Baltin	ore			1 XYes 2 □ No
	or 28	Director	10e. Street and Number	10f.	Zip-Code	10g.	Citizen of What Country	?
	s 23a	eral	3108 E. Federal -	StreeT	A1213	pecify Yes or No-	14. Race - American	Indian
(0	r item	Funeral	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No.		ecedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.	
93	ours a	þ	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 □ Ye	s 2 No Specify:		Specify. Blac	.K
5-0	"natur	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give kind o.	Usual Occupation f work done during most of work T use retired)		o. Kind of Business/Indus	stry
21215-0036	within ene. than	duic	Elementary/Secondary (0-12) College (1-4 or 5+		tician	7	Party Sil	00
	illed Hygi other ent, tl	BeC	17. Father's Name (First, Middle, Last)			ne (First, Middle, Mal	den Surname,	
/lar	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	일 의	Glossy Christmas		Cora	Etta	Finney	
Maryland	2 sho and I is ma		19a. Informant's Name/Relationship (Type. Print)	en)	Iress (Street and Number or Ru	1/1	ty or Town, State, Zip Co	ode)
	1 and 2 Health em 27		20a. Method of Disposition	20b. Place of Disposition	UnCan Ave,	Veaclon Date 200	Location - City or Town) , State
nor	Pages nent of h nt: If ite		1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposition cemetery, crematory		1-2009 Fe	rnwood S	PA 19050
Baltimore,	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Licensee		e and Address of Facility	0300 18	917W75	bella Street
<u>m</u>	any any		Martally M.	Ben	nie Smith Fun	eral Home		10 21801
			23a. Part 1. Effective disease, or complications that caused the shock, or heart failure. List only one cause on each line.	ne death. Do not enter the	mode of dying, such as cardiad	or respiratory arrest,	• In	pproximate Iterval Between Inset and Death
	Physician				Cardiovascu	las Disc	ase	
	/Medical Examiner		Due to (or as a	consequence of):				
A		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	consequence ofy:				
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events					
Ö,	e execian ar		resulting in death) Last Due to (or as a	consequence of):				
68760,	rificate be executed ig physician and as the burial-transit	Medical	d					
	E 5 0	_	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of				23d. Date of delivery	
Вох	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physician	in the past 12 months? 1 ☐ Yes 2 【No 9 ☐ Unknown		pic pregnancy r (specify)		Month Da	ay Year
P.O.	at the by the		9 Unknown Part II. Other significant conditions contributing to death but	t not resulting in the underly	ving cause given in Part I	23e Did tobac	co use contribute to the	cause of death?
	ires th	d by	Tarking Still Significant Schallsons Solition Stilling to Seattly Sal	, not recalling in the given	, and the second	1 🗌 Yes	2 No 3 Probab	
COL	requipeen s	lete		•		24a. Was an	24b. Were autops	y findings available
Division of Vital Records,	he law e has l age 2	Completed				autopsy performed 1 \(\sum \) Yes 2 \(\begin{array}{c} \text{2} \end{array}	l? death?	pletion of cause of ☐ No
ita	an: T tificate	Be C	25. Was case referred to medical examiner?			th (Check only one)		
<u>></u>	hysici nis cer al direc	၉	1 XYes 2 No				e 6 🗆 Other (Specify)	
u C	Ing P	ion	27. Manner of Death 28a. Date of Injury 1	/ear) 28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how i	njury accurred	
/isi	Attend death ctor: /	ficat	3 Suicide 6 Could not be 28e. Place of injury	y - At home, farm, street, far			et and Number or Rural P	Route Number,
ă	al or / s after il Dire	Certification:	4 ☐ Homicide determined building, etc.	(Speciny)		City or Town, St	ate)	
	To the Hospital or Attending Physician: The law requires that within 24 hours after death. To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be do	Medical	29a. Certifier (check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of eand manner state	examination and/or investigation	rred at the time, date and place ation, in my opinion, death occi	e, and due to the caus urred at the time, date	e(s) and manner as state and place, and due to t	ed. :he cause(s)
	o the	Mec	29b. Signature and title of certifier		29c. License number		Date signed (Month, Da	y, Year)
	0		> for their		00053368	fe	bruory 2	6,2009
	6 m		30. Name and address of person who completed cause of de	ath (Item 23a) (Type, Print)	600		St, Baltimore	
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar	s Signature	500	1401til Wolle	Ji, Dalilliole	, 1110, 21201
	Registi		FEB 27 2009 Sever	D. park				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Certifica	ate of Death	Reg. 1	2009 0820
Physicia	ın/	1. Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death
ledical Exami	ner	Carl W. Whitehead		Month Da March 2, 200	9 19151115
Charles .		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Centreville		4c. County of Death Queen Anne's
<u> </u>		Dill Farm Lane 5. Social Security Number 6, Sex 7. Age (In yrs. last birth		R Date of Birth/A	MM/DD/YYYY) 9. Birthplace (State or
Funeral Director			Months Days Hours Min	Nov 26	,1929 CountryNew York
5.100.01	-		Yrs	100.20	, 1929 Could New TOLK
any	ŀ	Usual Residence of Decedent 10a. State	or Location		10d. Inside City Limits
* ,	_	NewYork Niagara Lockpo	ort		1 X Yes 2 No
arylar 8a-f s	Director	10e. Street and Number	10f, Zip Code	10g.	Citizen of What Country?
th the Maryland 23a or 28a-f show notified at once.		7 Crosby Avenue	14094	U	.S.A.
with ns 23 be.no	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S		14. Race - American Indian, Black, White, etc.
death or ite	Ě	1 Never Married 2 X Married Armed Forces? 1 X Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	
s after	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:	Ido	Specify: White
hours natu		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret		b. Kind of Business/Industry
36 hin 72 e. Ifhan dical	Completed	1 2	ecurity Guard	r	rash Disposal
5-0036 iled within 7 Hygiene. I other than	5	17. Father's Name (First, Middle, Last)	18.Mother's Name	e (First, Middle, Maid	den Surname)
21215-0036 Uld be filed within 72 Mental Hygiene. marked other than 'e vent, the Medical	Be	Harry Whitehead	Elsie	Gottshal	k
e, MD 21215-003 1 and 2 should be filed within Health and Mental Hygiene, item 27 is marked other the r traumatic event, the Med	ပ္		. Mailing Address (Street and Number or		
ore, MD ss 1 and 2 sho of Health and If item 27 is her traumati			Crosby Avenue, Loc		Oc. Location - City or Town, State
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. unt: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once		1 Burial 2 Cremation 3 Removal from State cremato	ory or other place)		•
imc Page ment tant: or of		4 Donation 5 X Other SpecifyEntombment Gles	nwoodMausoleum 3	-12-09 I	ockport, New York
Baltimore, pervit. Pages La Department of Her Important: If ite		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Ma	zullo F	uneral Chapel, P.A
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do no	6009 Hartord Road tenter the mode of dying, such as cardiac	ad, Balti or respiratory arrest,	more, Maryland2121 shock, or heart Approximate Interval
/Medical		failure. List only one cause on each line.	y Hypertensive Cardiovascular D		Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	y Hypertensive Cardiovascular D	156456	
		Sequentially list conditions, b			
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
ansit fed SAN	am	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
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be exe ician a	Medical	UNPENDED AMENDED			
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and icly filled in by the funeral director, page 2 should be detached for use as the burial - transit		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	S. L. L. W. 2 Estania proces	220	23d. Date of delivery Month Day Year
Sox 687 death certific e attending p	sician	past 12 months? 1 Live birth 2 4 Pregnant at time of death	Fetal death 3 Ectopic pregn Other (Specify)	aricy	Month Day Year
Box ne death c the atten	Physi	1 Yes 2 No 9 Unknown 9 Unknown	Other (opcomy)		
od by tetache	by Pi	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.	1 —	cco use contribute to the cause of death?
s, P.C nires that n signed to d be deta					2 No 3 Probably 4 V Unknown
cords law requi	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Reco	E			performe 1 ✓ Yes 2	d? death? No 1 Yes 2 No
of Vital Records, g. Physician: The law requir After this certificate has been s neral director, page 2 should t	Be C	25. Was case referred to medical examiner?	26.Place of Death (Check	only one)	
of Viting Physic	P	1 ✓ Yes 2 No Hospital 1 Inpatient 2 ER/O			sidence 6 V Other: Scene
1 of ding Pt After funeral	- 4	1 Notural FO(Month, Day, Year) FO(I	Time of Injury 28c. Injury at Work? IND: 1 Yes 2 ✓ No	28d. Describe how Subject expos	ed to cold environment
ivisior for Attendafter death Director:	cati	2 ✓ Accident Investigation Mar 2, 2009 1915	5 hrs	20f Lanction (Stro	et and Number or Rural Route Number, City
Division pital or Attendi ours after death. teral Director:	Certification:	Suicide 6 Could not be determined (Specific) Field	arm, street, factory, office building, etc.	or Town, State Dill Farm Lane,	e)
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a, Certifier	oth occurred at the time, date and place, an	1	
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner:On the basis of examination and/or in	nvestigation, in my opinion, death occurred	at the time, date and	d place, and due to the cause(s)
To with To con	Me	and manner stated. 29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Month, Day, Year)
		DL MOIL IMO	O.C.M.E.	1	March 3, 2009
		30. Name and address of person who completed cause of death (Item 23a)			
10		Donna M. Vincenti, MD Assistant Medical Examiner	111 Penn Street, Baltimore, N	MD 21201	<u>.</u>
S	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	a. d. d		
			arles	······································	
DHMH 17 Rev 1/2	001	OR	RIGINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2009 08205 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year 9:43 6 onn 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Baltmore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Hours Year 1 ☑ M 2 ☐ F Yrs. 50 219-68-1697 28 1958 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 39 Thomas Road 21060 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2√2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ∐Yes 2 ⊠No White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Tractor Trailers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emerick F. Abell Patricia Malseed 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria A. Abell (spouse) 39 Thomas Road, Glen Burnie, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) March Date 20c. Location - City or Town, State 1 ☐ Buriel 2 € Cremation 3 ☐ Removal from State 2009 Baltimore, Maryland 4 Donation 5 Other (Specify) Metro Crematory Inc. 22. Name and Address of Facility Stallings Funeral Home, P.A. 21. Signature of Funeral Service Licenses 3111 Mountain Road, Pasadena, MD 21122 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

rel", or items 23a or 28a-f st Examiner must be notified

other than "

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than eny Injury or other traumatic event, I've Monce.

Director

Completed by Funeral

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

10a. State

1	Medical Certification: To Be Completed by Physician/Medical Examiner	
	completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit	
	To the Funeral Director: After this certificate has been signed by the attending physician and	
	within 24 hours after death,	

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

SHOCK, OF Heart failure. List Offly o	rie pause on each line.				Onset and Death
Immediate Cause (Final disease or condition	Sepsis				Oliset and Death
resulting in death)	Due to (or as a consequence of):				
Sequentially list conditions	b. AML				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
R I that initiated events	c				
resulting in death) Lest	Due to (or as a consequence of):				
	d				
IF FEMALE:					
23b. Was decedent pregnant in the past 12 months?		topic pregnancy		23d. Date of del Month	ivery Dav Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of death 5 ☐ Oth 9 ☐ Unknown	ner (specify)		WOTH	Day Teal
	ontributing to death but not resulting in the under	ving cause given in Part I	23e Did tobacco	use contribute to	the cause of death?
T are morning organic organic organic organic	and build to death but not resulting in the under	ying cause given in rairi.			obably 4 Unknown
			Tores	2 NO 3 FI	ODADIY 4 OTKHOWN
			24a. Was an autopsy	prior to o	topsy findings available completion of cause of
5			performed?		2 No
25. Was case referred to medical examiner?			h (Check only one)		
I les ZZIVO	Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3	☐ DOA Other: 4 ☐ Nursing Ho	me 5 Residence	6 ☐ Other (Spe	cify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how inj	ury occurred	
2 Accident investigation 3 Suicide 6 Could not be		M 1 ☐ Yes 2 ☐ No			
4 Homicide determined	28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street a City or Town, Sta	and Number or Ru te)	ral Route Number,
29a. Certifier 1 Certifying Phy	ysician: To the best of my knowledge, death occ	curred at the time, date and place.	and due to the cause	(s) and manner as	s stated.
(Check only 2 Medical Exam	iner: On the basis of examination and/or investi and manner stated.	gation, in my opinion, death occur	red at the time, date a	nd place, and due	to the cause(s)
29b. Signature and title of pertiner		29c. License number	29d. 5	Date signed (Monti	n. Dav. Year)

P22164

S. Greene St, Baltimore, MD

Registrar DHMH 17 Rev 1/2001

State

15

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22 32. Registrar's Si

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 08206 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Grant E₁y Acker Marut 13 2000 4.20PM /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SATTIMORE WASHINGTON MEDICAE CENTER BNNB MINIDE N BURNIE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year, Nov. 20, 1 Birthplace (State or Foreign Country)

 DA **Funeral** Months Days Hours Min 1 □XM 2 □ F 84 190-16-1742 Director Usual Residence of Decedent the Maryland 10b. County 10a, State 10c. City. Town or Location 10d. Inside City Limits show ns 23a or 28a-f shor Director 1 ☐ Yes 2 No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 808 Stewart Avenue 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? ↑☐Yes 2☐No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any injury or other traumatic event, I'm Madical Evantina. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Chief Warrent Officer US Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert A. Acker ပ Rebecca K. Dunmoyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 808 Stewart Avenue S.W. Glen Burnie, MD 21061 Mrs. Dorothy Ferres-Acker/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 20. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vets.Cem. Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or explications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final . Physician MEUMONI disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DUGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit ISCHEMIC Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş icate has been si, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform certificate 1 □ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day, Year) in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled 1 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29b. Signature and title of certifier 29c. License number 0

10+1

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Glen burnie mis soibi

State of Maryland / Department of Health and Mental Hygiene 09 08207

		_	For State Registrar		or iviaryia		ertificate of			Reg. No.	3 08201
-	Physicia		1. Decedent's Name (First, Midd						2. Date of De	Day Yea	
	/Medic	al	Philip George 4a. Facility Name (If not institution)				4h City Town	or Location of Deat	March	4c. County of De	
	Examin	er	Levindale Ho		arriber)		Balti			, o. dounty of De	
	Funeral	20	5. Social Security Number	6. Sex	7. Age (In yr.	s. last birthday) If Under 1 Year Months Days		8. Date of Birt	th 9. B	Sirthplace (State or Foreign
ш	Director	ļ	218-14-9008	X M 2□ F	85	Yrs.	IVIOTITIS Days	Tiodis Will.	Septemb	y, Year) per 22, 192	3 Maryland
	and w	}	Usual Residence of Decedent 10a. State 10b. Count	у	10c. (City, Town or L	ocation				10d. Inside City Limits
	Maryli f sho led at	ò		alto.		Per	ry Hall				1 □Yes 2 No
	r 28a- notif	irec	10e. Street and Number			101	10f. Zip Code			10g. Citizen of What	Country?
	th with	al D	4514 Forge Ro	oad			21	128		USA	
	ems er mu	ner	11. Marital Status	Armed F	cedent Ever in orces?	U.S. 13	. Was Decedent of If Yes, specify Cut	Hispanic Origin? (S can, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14. Race - Ar Black, WI	nerican Indian, hite, etc.
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	1 ☐ Never Married 2 ☐ Ma 3 ☐ Midowed 4 ☐ Divorce	If Yes G	2 ☑ M No live Dates:		1 ☐ Yes 2 🛣 No	Specify:			White
5-0	72 h "natu dical	etec	15. Decede (Specify only high	ent's Education lest grade completed)	16a. Dec (Giv	edent's Usual Occu e <i>kind of work done</i> DO NOT use retire	pation during most of wo	rking	16b. Kind of Busines	ss/Industry
121	within ane. than '	dm	Elementary/Secondary (0-12)	College	(1-4or 5+)	Buye		<i>∍a)</i>		Supply	Company
d 2	filed v Hygie Ither	ပ္တို	17. Father's Name (First, Middle			Daye		18. Mother's Na	me (First, Middle,	Maiden Surname)	Company
an a	ld be lental ked o ic eve	o B	Joseph B. But	t				Elizab	eth C. k	Kah1	
ary	shou and M s mar umat		19a. Informant's Name/Relation	nship (Type. Print)		19b. Mai	ling Address (Stree	t and Number or R	ural Route Numbe	er, City or Town, State	, Zip Code)
Ξ	and 2 salth a n 27 is		Loretta Butt		DTR.	7	Tommy Tr	ue Court		lle, Md. 2	
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal fron			oosition (Name of ematory or other pla		Date	20c. Location - City	
Ē	ment tant: jury		4 Donation 5 □ Other	(Specify)	Me		l Mem. Pa		-2009	Parkville	•
Baltimore,	permit Depar Impor any in		21. Signature of Funeral Service	e Licensee	rick	2				Funeral I	
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that st only one cause on	caused the de	ath. Do not e	nter the mode of dy	ing, such as cardia	c or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_a de	2men't	ha					Onset and Death
	/Medical Examiner		resulting in death)	Due to	o (or as a cons	equence of):					
- 1:		er	Sequentially list conditions, if any, leading to immediate	b. — Due to	o (or as a cons	equence of):					
NE	uted j ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1							
0	rificate be executed ig physician and as the burial-transit	Еха	resulting in death) Last	Due to	(or as a cons	equence of):					
68760,	ate be nysiciá he bu	edical		d							
	ertifica ling ph e as t		IF FEMALE:	00- 15							
Вох	Attending Physician: The law requires that the death cer rdeath. ector: After this certificate has been signed by the attendin by the funeral director, page 2 should be detached for use	Completed by Physician/N	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome pf preg birth 2 Fe gnant at time o	etal death 3	☐Ectopic pregnand	су		23d. Date of o	delivery Day Year
	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐Unk		i dealii - 5	Other (specify)_				
, P.O.	that hed by deta	y Ph	Part II. Other significant condi	tions contributing to	death but not re	esulting in the	underlying cause gi	ven in Part I.	23e. Did t	obacco use contribute	to the cause of death?
rds	w requires to been signer should be o	q pe	depress	on					10	Yes 2XNo 3□	Probably 4 ☐ Unknown
တ္တ	law re as bee 2 sho	plet	_ depress	temia					24a. Was		autopsy findings available to completion of cause of
Ä	The late happe	yom)							perfo	ormed? death	?
/ita	ysician: This certificate	Be C	25. Was case referred to medic examiner?						ath (Check only o	one)	
Division or Vital Records,	Physic this c	²	1 Yes 2 No				SILL OLI DOX		1	dence 6 Other (S	pecify)
n C	tending Pheath. tor: After the	ion:	27. Manner of Death 1 Natural 5 □ Pend	/8.6-	e of Injury onth, Day Year)	28b. Time Injury	We	ork? ☐Yes 2☐No	28d. Describe	how injury occurred	
isi	Attend death cctor: ,	fical	3 Suicide 6 Coul	d not be 28e. Plac	ce of injury - At	home, farm, s	street, factory, office			Street and Number or	Rural Route Number,
	al or Att	Certification:	4 ☐ Homicide deter	buil	ding, etc. (Spe	city)			City or Tox	vn, State)	
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one) Certify Medica	ring Physician: To the al Examiner: On the and ma	ne best of my k basis of exami	nowledge, dei ination and/or	ath occurred at the investigation, in my	time, date and place opinion, death occ	ce, and due to the curred at the time,	cause(s) and manner date and place, and c	as stated. due to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certif	fier			29c. Licer	ise number		29d. Date signed (Mo	onth, Day, Year)
			· h	- N	10		D69	4206		March 11	. 2009
	12		30. Name and address of person	2434	west !	Beive	dere A	tvenue	Baltin	nore up	21201
ľ	Sta Registi		31. Date filed (Month, Day, Yea	2009	Registrar's Sig	ture	N. J.				

State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day 1 4 , Month Da MARCH Year 2/2/2/9 Physician 12:42M George Edward Bittner, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Joseph Medical Center Baltimore Saint OWSON Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 ☑ M 2 ☐ F 217-22-9068 82 2/28/1927 Balt., Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show the Medical Exerciters, ust be notified at 1 ☐ Yes 2 ☑ No Maryland Baltimore Phoenix Director 10g, Citizen of What Country? United States of America 10f. Zip Code 10e. Street and Number 21131 3709 Blenheim Road 23a 72 hours after death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No or items 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: white Yes. Give þ "natural", 3 → Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) les 1 and 2 should be filed within of Health and Mental Hygiene. If item 27 is marked other than " or other traumatic event, the "his Elementary/Secondary (0-12) than College (1-4or 5+) Master Plumber self employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Proudy George Edward Bittner, Sr. ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 205 Fountain Court Timonium, Maryland 21093 Debra L. Michael/ daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens 20c. Location - City or Town, State Pages 1 20a. Method of Disposition March 17, permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A.
2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licensee / (r 10 Approximate Interval Between Onset and Death 23a, Part 1. Er er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ACUTE RESPIRATORY DISTRESS SYNDROME disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEPSIS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sician and burial-transit Exami PNEUMONIA Due to (or as a consequence of): attending physician for use as the buria certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a ☐Yes 2☐No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 Probably 4 Unknown ACUTE RENAL FAILURE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy spital or Attending Physician: The ours after death.

neral Director: After this certificate hilled in by the funeral director, page 1 ☐ Yes 2 ☐ No 1 □ Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 X No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month Day, Year) 29c. License number 29b. Signature and title of certifier 30446 death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of MARYLAND 21204 TOWSON. HORNEFFE M. D. 7601 OSLER DRIVE. PETER 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #1 Per State of Maryland Department of Health and Mental Hygiene

			For State Registrar	State of Ma	ii yiaiiu / L		tificate of l		and Me		Reg. No.		082	09
	Physici	an	1. Decedent's Name (First, Middle, La Charles T							Date of Dea Month	Day		3. Time of D	
100	/Medic		4a. Facility Name (If not institution, giv		an		4b. City, Town, or	Location of		larch	14 4c.	2009 County of Dea	07:00	A
ة المحمد	Examin	er	Tate Hospice Hous					hicum				Anne Aı		
	Funeral		Social Security Number 6. S	ex 7. Age	(In yrs. last bir		If Under 1 Year Months Days	If Under	24 Hrs. 8. Min.	Date of Birth (Month, Day	Year)	9. Bir	thplace (State or ountry)	Foreign
	Director		216-32-6132 Usual Residence of Decedent	X W Z L	71	Yrs.				pril 2		937	MD	
	ow ow		10a. State 10b. County		10c. City, Town	or Loc	ation						10d. Inside City	Limits
	a-f sh	ctor	Maryland Anne A	rundel			G	Glen E	Burnie				1 ☐ Yes 2	! ☑ No
	or 28	Director	10e. Street and Number				10f. Zip Code				10g. Citi:	zen of What Co	untry?	
	s 23a	rai	210 N. Crain Hwy	_		140.11	2 1 1 1 1	2106		Va a va Na		USA	* b0	
	item item	Funeral	11. Marital Status1 ☐ Never Married 2 ☐ Married	12. Was Decedent I Armed Forces? 1 □ Yes 2 ☑ N		13. V	Vas Decedent of H Yes, specify Cuba	an, Mexicar	n, Puerto Ric	y res or No- an, etc.)		 Race - Ame Black, Whit 		
036	urs af	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1	□Yes 2⊠No	Specify:				Specify:	White	
21215-0036	filed within 72 hours after death with the Manyland Hygiene. yther than "natural", or items 23a or 28a-f show ent, the Medical Experience must be metitled at	Completed	15. Decedent's E	ducation ade completed)	16a.	Deced	ent's Usual Occup kind of work done of OO NOT use retired	ation during mos	t of working		16b. Kir	nd of Business	Industry	
121	vithin sne. than "	du	Elementary/Secondary (0-12)	College (1-4or 5	+)		ONOT use retired tronic T				Ta7	estingh	01100	
0	filed v Hygie other i		17. Father's Name (First, Middle, Last)		1100	teronic i		er's Name (F	irst, Middle,			louse	
lan	fid be fental rked o	To Be	Unknown						Ur	ıknown				
Maryland	2 should and Mer Is marke raumatic		19a. Informant's Name/Relationship	Type. Print)	19b	. Mailing	g Address (Street	and Numbe	er or Rural R	oute Numbe	r, City o	r Town, State,	Zip Code)	
	1 and 2 Health tem 27 I		Nancy A. Bevan	(spouse)			N. Crain							
Jore	Pages 1 nent of h ant: If ite ury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐				sition (Name of patory or other place	1.1	Date March	18		cation - City or		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expenditure in saf be notified at once.		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Light	4 4	Metro	_	matory I: Name and Addre		2009				Maryland	
Ba	permit. Departr Importa any inje		Muchill	Haller	(1)		3111 Mou		Sta	_			lome, P.A	1 .
			23a. Part 1. Enter the disease, or com- shock, or heart failure. List only	plications that caused	the death. Do							, 110 21	Approximate Interval Between	een
and it	Physician		Immediate Cause (Final disease or condition		- Section 1		DISEASE						Onset and De	ath
	/Medical Examiner		resulting in death)		a consequence									
	LAdiiiiici	<u>_</u>	Sequentially list conditions,	b. Due to (or as	a consequence	of)·								
Q.	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Liner Unionlying Cause (Disease or injury	500 10 101 00	2 0011004201100							-		
oʻ	e exec an and riaf-tra		that initiated events resulting in death) Last	Due to (or as	a consequence	of):								
68760,	rificate be executed ng physician and as the burial-transit	Jedical		d										
		Mec	IF FEMALE:	23c. If yes, outcome	of pregnancy									
Вох	ires that the death cer signed by the attendin d be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death		Ectopic pregnanc Other (specify) _	ÿ			2	23d. Date of de Month	Day Ye	ar
P.O.	t the c by the achec	hysi	1 □Yes 2 □ No 9 □ Unknown	9 Unknown										
S, F	es tha igned be det	by P	Part II. Other significant conditions	contributing to death be	ut not resulting in	n the un	derlying cause giv	en in Part I					the cause of dea	
ord	w requir been s should	ted			<u> </u>					1 ∐ Y	es 2[_No 3 P	robably 4 Un	known
Records,	e la has	Completed								24a. Was a autop: perfor	sy	24b. Were an prior to death?	utopsy findings av completion of cau	railable use of
a	ician: Th certificate ector, pag		25. Was case referred to medical					00 PI		1 □Yes	2 No	1 ☐ Yes	2 N 0	
<u>=</u>	ysicia s cert directe	o Be	examiner?	Hospital:	nt 2□ER/O	utpatient	t 3 DOA Oth	er.	e of Death (Cursing Home			Other (Spe	HOSPIC Gifty HOSPIC	عر
n 01	ng Ph fter th	J:T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju	ry 28b.	Time of Injury	28c. Injur Worl	ry at		l. Describe h		_		
sio	tendii leath. tor: A the fu	catic	2 Accident investigatio 3 Suicide 6 Could not b					Yes 2						
Division of Vital	or At after d Direct in by	Certification: To	4 Homicide determined		iry - At home, fa c. <i>(Specify)</i>	ırm, stre	eet, factory, office		281.	City or Tow	itreet and n, State)	d Number or R)	ural Route Numbe	∍r,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 CertifyIng P	hysician: To the best	of my knowledg	e, death	occurred at the til	me, date ar	nd place, and	d due to the	cause(s)	and manner a	s stated.	
	he Ho in 24 I he Fu ipletel	Medical	(Check only 2 Medical Exa	miner: On the basis o and manner sta		nd/or inv	estigation, in my o	opinion, dea	ath occurred	at the time, o	date and	place, and du	e to the cause(s)	
	Vith Vith Con	Σ	29b. Signature and title of certifier	2	_		29c. Licens					e signed (Mon		
	بہ		Pronna W.		MD (None and	/T	0005	473	9	٨	IAR	CH 16	th 2009	
	5		30. Name and address of person who 7845 OAKWOOD					PALLE	. MA		06	i		
	Sta	te	31. Date filed (Month, Day, Year)	RDAD SU 32. Registr	ar's Signature	مدر	1	NIC	MIS	21	00			
	Registr	ar	MAR 1 7 2009	Clave	p. 19	TI CA								

			For State Registrar	State of	Maryland		rtmen <i>tificat</i>			and M	lental Hy	giene Reg. No.	71114	08210
	Physicia		1. Decedent's Name (First, Middle, Last Catherine Phyllis						-		2. Date of Dea Month	ath Day		3. Time of Death
	/Medica		4a. Facility Name (If not institution, give	street and numi	ber)				Location o				County of Death	
	Funeral		5. Social Security Number 6. Se	× pital	. Age <i>(In yrs. la</i>	ast birthday) Yrs.	If Under Months		If Under Hours	•	8. Date of Birt	h Year)	Cour	place (State or Foreign ntry)
ס	irector		Usual Residence of Decedent								J J 17.		Kans	
Aarylan	f show	ğ	10a. State 10b. County Maryland Baltimor	·e		Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☐ No
th the N	or 28a- e notifi	Funeral Director	10e. Street and Number			7110 7 1 1	10f. Zip						izen of What Cou	ntry?
eath wi	s 23a nust b	eral	15 Maiden Choice I	Jane H	IV518	112 1		1228	spanio Ori	igin2 (Sn	acify Vas or No		ted Stat	,
21215-0036 within 72 hours after death with the Maryland	0,1	ğ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Ford 1 Tes 2 If Yes, Give Year or Dat	es? La No A	i	fYes, spec		Specify:		ecify Yes or No Rican, etc.)		Black, White,	etc.
Baltimore, Maryland 21215-0036	"natur	Completed	15. Decedent's Edu (Specify only highest grad	le completed)		16a. Deced (Give life. L	dent's Usua kind of wor DO NOT us	al Occupa k done d se retired	ation <i>Juring mos</i>)	t of worki	ing	16b. Ki	ind of Business/In	dustry
212 ad withi	ygiene.	Com	Elementary/Secondary (0-12)	College (1-4	lor 5+)	Nur							dical	
and d be file	c even	To Be	17. Father's Name (First, Middle, Last) Richard Dick Kean	nev						er's Name nknov	e (First, Middle, I n	Maiden	Surname)	
ary!	and Mi is marl aumati	ř	19a. Informant's Name/Relationship (7			19b. Mailir	g Address	(Street &				er, City o	or Town, State, Zij	o Code)
e, M	Health		Nancy Mannion / Da 20a. Method of Disposition	ughter	20b. Pl						inthicu		Maryland ocation - City or To	
mor Pages	nent of nt: If its ry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		ate	ace of Dispo emetery, cren adowria			i				idge, Ma	
Balti permit.	Departn Importa any inju once.		21. Signature of Funeral Service Licens	ee A	11-	22	. Name an	d Addres	s of Facilit	Gary	L. Kau	ıfmaı	n Funera	1 Home, Inc
			23a. Part 1. Enter the disease, or compa shock, or heart failure. List only of	lications that ca	sed the death								e, Maryl	and , 21075 Approximate Interval Between
	ysician Iedical		Immediate Couse (Final disease or condition resulting in death)	a Rupt	-urcl	Thor	×ره -	Abd	omiv	nal .	Aortic	Av	reurysm	Onset and Death
The second secon	aminer			Due to (o	r as a consequ	ence of):								
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8760,55; cate be executed	physician and the burial-transit	Exar	that initiated events resulting in death) Last	c Due to (o	r as a consequ	ence of):								
68760,	physici s the bu	edical		d										
TNE O. Box (within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 ryonths? 1 □ Yes 2 ☑ No 9 □ Unknown		rth 2□Fetal ant at time of de	death 3	Ectopic p Other <i>(sp</i>		′				23d. Date of deliv Month	rery Day Year
HERIN ds, P.O. B	signed by	by Ph	Part II. Other significant conditions of	ntributing to dea		0			-	ibrilo		obacco u Yes 2	,	the cause of death?
CATHE Records,	s been should	oleted	chronic Obstruc	1			•		rior		24a. Was	an	24b. Were auto	opsy findings available
A Rec	page 2	Com		sm ve		1		,			autor perfo 1 □ Yes	rmed? 2 ☑No	death?	ompletion of cause of 2 No
8, Vital	s certific irector,	B	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	patient 2 🗆 I	EB/Outpatier	4 3 🗆 D(Othe	or.		h <i>(Ch</i> eck only o		6 □Other (Speci	(6.1)
BLO (on of ding Phys	fter this neral d	on: To	27. Manner of Death 1 Natural 5 Pending	28a. Date o		28b. Time o Injury		8c. Injury Work	4 🗆 190		28d. Describe			<u>''y)</u>
Bivision	after death. Director: A Lin by the fu	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place C	of Injury - At ho g, etc. <i>(Specif</i> y	me, farm, str	M eet, factory		Yes 2□		28f. Location (. City or To	Street an vn, State	nd Number or Rur e)	al Route Number,
The Hospital	n 24 hours ne Funeral pletely fillec	Medical C	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	/sician: To the bainer: On the baand manne	sis of examinat	wledge, deat tion and/or in	h occurred vestigation	at the tir , in my o	ne, date a pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s date and	s) and manner as d place, and due	stated. to the cause(s)
Tot	To the	Σ	29b. Signature and title of certifier	MD			290	_	820	5			te signed (Month,	
	٦		30. Name and address of person who of	St Agn	is Hospit	al, 90	o cat	on A	we,	Balt	imove,		21229	
	Sta Registra		31. Date filed (Month, Day, Year)	2009 32. Re	dstrar's Signat	D. A.	park	1						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 11:30P^M Janet M.L. Bennett 03 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 810 East Seagrove Road Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🕅 F 214-46-1616 03-24-1947 MD **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mentical Examples. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ∐Yes 2**√**∑No Director MD Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21060 U.S.A. 810 East Seagrove Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ∐Yes 2XX No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 □Yes 2 🛣No Specify: White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dog Trainer Pet Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Hame 11 Doris Haddaway 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) / Husband Mr. Richard W. Bennett 810 East Seagrove Road Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Holy Cross Cem. 03-20-2009 Brooklyn , MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitySingleton Funeral & Cremation Srv eture of Funeral Service Licensee alle P.A., 1 2nd Avenue SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Wort disease or condition resulting in death) /Medical Due to (as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical as attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 5 Other (specify) signed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed 2 No this certificate 1 ☐Yes 2 ☑No 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ Ño 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 ☐ Pending investigation → Natural To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, 29b. Signature and title of certifier 29c. License number nd address of person who completed cause of death (Item 23a) (Type, Print) V 556 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** :1500 2009 03 Robert William /Medical Brooks 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Franklin Square
5. Social Security Number 6. Se rose dale HOSPI tal TIMORE Center Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1**X** M 2□ F Months Hours Min. 8/13/1940 Maryland Director 217-38-9250 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County a or 28a-f show be notified at 1 ☐ Yes 2X No Directo Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code rai", or items 23a Examiner must b 316 Lorraine Avenue Completed by Funeral <u> 21221</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 🎾 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry is marked other than "naturaumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Mechanic Automobile 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) To Be Carl **Brooks** Violet 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If Item 27 is any injury or other trauonce. Dorothy May Brooks (wife) Essex, 316 Lorraine Avenue Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue Maryland 21221 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): 4 months disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy 1 ☐ Live birth Day in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient Vo the rusperser within 24 hours after death.

To the Funeral Director: After this of the Funeral director is the funeral director. ဥ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical (1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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Registrar
DHMH 17 Rev 1/2001

State

Dr. Minus

31. Date filed (Month, Day,

D00GU755

3/14/09

9000 Franklin Square Drive, Baltimore MD, 21237

4M, BOADIZAV

MD

30. Name an Underess of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year BROGUNIER WILBUR MARCH 2009 15.55 PM 12

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Hours

Baltimore

Days

Months

4c. County of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

Mary Land

8. Date of Birth (Month, Day, Year)
May 21, 1925

Physician /Medical **Examiner**

4a. Facility Name (If not institution, give street and number)

HARIBOR HUSPITAL

10b. County

6. Sex

1 € M 2 □ F

7. Age (In yrs. last birthday)

10c. City, Town or Location

83

5. Social Security Number

218-18-7238 Usual Residence of Decedent

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, it with the injury or other traumatic event, it with a page.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-tran After this of funeral dire To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fur

Division of Vital Records, P.O. Box 68760

1 ☐ Yes 2 🛛 No Baltimore Baltimore Directo Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 2763 Norfen Rd. 21227 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∏Yes 2 ∏ No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21X No Specify. Specify: White þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Greyhound Bus Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth (Unknown) Wilbur Brogunier ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2778 Virginia Ave., Baltimore, MD 21227 Bonnie Brogunier (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 3/16/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service License 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition SEPS15 resulting in death) Due to (or as a consequence of): TRACT INFECTION JRINARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐ No 1 ☐ Yes NO Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 MARCH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

SHEENU SHEELA 31. Date filed (Month, Day, Year)

32. registrar's Signature

3001 S. HANOVER STREET, BALTIMORE MARYLAND, 21225

Division of Vital Hospital or Attending Physician: 24 hours after death. within 2 To the F

29a. Certifier 1

29b. Signature and title of certifier

ca

State Registra

30. Name and address of person who completed cause of death (item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Mg)

ns

and manner stated

Registrar's Signa

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 13, 2009

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day_ Month MARCH ZMD9 **Physician** Preston Rice Chilcoat 02:19FM /Medicat 4c. County of Death Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Towson Joseph Medical Saint Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours 1 X M 2 □ F 80 02/24/1929 217-24-2735 Buffalo, NY Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Parkville Baltimore 1 ☐ Yes 2 No MD Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 U.S.A. 1924 Shanklin Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Korean Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Commerical College (1-4or 5+) Elementary/Secondary (0-12) Salesman 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Adele Cunningham Melvin Chilcoat ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1924 Shanklin Ave. Parkville, MD 21234 Gloria Chilcoat/ Wife Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Evans Funetair place) 03/15/09 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) Chapel-Bel Air 21. Signature of Funeral Service Licensee EValusant where the Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 3a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or he in failure. List only one cause on each line. Approximate Interval Between Onset and Death resulting in death) **Physician** GRAM NEGATIVE BACTEREMIA /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical attending properties of the second IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Year 5 Other (specify) signed by the a ☐Yes 2☐No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 2 No 3 Probably 4 Unknown RESPIRATORY FAILURE 1 🗆 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an CLOSTRIDIUM DIFFICILE COLITIS has autopsy perform 1 □ Yes 1 □ Yes 2) 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending 1 Natural 2 Accident 5 ☐ Pending investigation a er death. 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

29b. Signature and title of certific

30. Name and address of person wh

OSLER DRIVE TOWSON, MARYLAND 32 Registrar's Signa

completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

D24034

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM 16b Perfft, G889, 3/20/09 WS
State of Maryland Perfft of Health and Mental Hygiene

		For State Programme (First, Middle, Last)	Cer	rtificate of D	1	2. Date of Death	g. N2 0 0	3. Time of Deat
Physicia /Medic		Marie C. Coughlin				March 15	2009	4:30A
Examin	er	4a. Facility Name (If not institution, give street and number Franklin Woods)	4b. City, Town, or L	Location of Death Sedale		4c. County o	Balto.
Funeral Director		5. Social Security Number 6. Sex 1 M 2 12-60-8997	ge (In <i>yrs. last birthday)</i> 87 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, July 29,	1921	9. Birthplace (State or Fore Country) Maryland
a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Md. Balto.	10c. City, Town or Lo	cation te Marsh				10d. Inside City Lin 1 ☐ Yes 21
a or 28.	Director	10e. Street and Number 5534 Apperson Rd.		10f. Zip Code 21162		10	g. Citizen of W	•
h tygiene. d other than "natural", or ltems 23a or 28a-f show event, the Medical Examinat must be indiffed at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Deceden Armed Forces 1 Yes 2 Fif Yes, GiveA Year or Dates	t Ever in U.S. 13. \ ?] No	Was Decedent of His If Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black	- American Indian, , White, etc. White
giene. or than "natur the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	(Give	dent's Usual Occupat kind of work done du DO NOT use retired)	tion uring most of worki	ing	Baltimo	ore Co. Sch
	To Be C	17. Father's Name (First, Middle, Last) Frederick Albrecht			18. Mother's Name Leo1a		laiden Sumame	
Department of Health and Mer Important: If item 27 Ia marke any injury or other traumatic once.		19a. Informant's Name/Relationship (Type, Print) Lawrence Coughlin 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Euneral Service Lice	Son 20b. Place of Disponsion commetery, creations	matory or other place	1yKno11 (Ct. Abir	nedon, N Oc. Location - C Balto. (Ad. 21009 City or Town, State City, Md.
a maga	11 19	Ily tilly						
		23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	line.	ter the mode of dying		or respiratory arre	st,	Approximate Interval Between
hysician and the burial-transit	dical Examiner	shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.	ine. EROSCL s a consequence of): HYPERT s a consequence of):	ter the mode of dying	, such as cardiac o	or respiratory arre	st,	Approximate Interval Between
ledical aminer and prize as the	edical	shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a d	line. EROSCL s a consequence of): HYPER s a consequence of): DIA s a consequence of): e of pregnancy 2 □ Fetal death 3□	ter the mode of dying EROTIC EN 510	, such as cardiac o	or respiratory arre	st, SEAS	Approximate Interval Between Onset and Death
been signed by the attending physician and upper should be detached for use as the burial-transit to the contract of the contr	by Physician/Medical	shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 PNo	line. EROSCL s a consequence of): HYPERT s a consequence of): DIA s a consequence of): e of pregnancy 2 Fetal death at time of death 5	TEROTIC EROTIC EROTIC EN SIO	, such as cardiac of HEAR	23e. Did tob	23d. Date Mon acco use contril 2 2 No.	Approximate Interval Between Onset and Death Onset and Death of delivery the Day Year Dute to the cause of death all Probably 4 Unknown of the cause of death of the cause of the cause of death of the cause of
as been signed by the attending physician and uipper 2 should be detached for use as the burial-transit	Completed by Physician/Medical	shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 PNo 9 Unknown Part II. Other significant conditions contributing to death	line. EROSCL s a consequence of): HYPERT s a consequence of): DIA s a consequence of): e of pregnancy 2 Fetal death at time of death 5	TEROTIC EROTIC EROTIC EN SIO	, such as cardiac of HEAR	23e. Did tob 1 Ye 24a. Was ar autops) perform	23d. Date Mon acco use contril s 2 1 No.	Approximate Interval Between Onset and Death Onset and Death of delivery the Day Year Dute to the cause of death? 3 Probably 4 Unknown of the cause of death?
inter dear Miles this certificate has been signed by the attending physician and Director, page 2 should be detached for use as the burial-transit of Islands.	To Be Completed by Physician/Medical	shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	line. ROSCL s a consequence of): HYPER s a consequence of): DIA s a consequence of): e of pregnancy 2 Fetal death at time of death 5 but not resulting in the u	ter the mode of dying EROTIC ENST BETE □Ectopic pregnancy □ Other (specify) underlying cause given at 3□ DOA of 28c. Injury Work M 1□ Y	n in Part I. 26. Place of Death r. at ursing Ho at ? es 2 \[\] No	23e. Did tob 1 Ye 24a. Was ar autops) 1 Yes 2 n (Check only one me 5 Reside) 28d. Describe hor	23d. Date Mon acco use contrib s 2 No General School Scho	Approximate Interval Between Onset and Death Onset and Death of delivery the Day Year butte to the cause of death 3 Probably 4 Unknown for to completion of cause path? Yes 2 2 No.
this certificate has been signed by the attending al director, page 2 should be detached for use a	o Be Completed by Physician/Medical	shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	line. EROSCL s a consequence of): HYPER s a consequence of): DIA s a consequence of): e of pregnancy 2 Fetal death at time of death 5 but not resulting in the u tient 2 ER/Outpatier jury ay Year) 28b. Time or Injury any Year) st of my knowledge, deat of examination and/or in	ter the mode of dying EROTIC ENST BETE BETE Characteristics Characte	n in Part I. 26. Place of Death ursing Ho at es 2 \(\subseteq \) No	23e. Did tob 1 Ye 24a. Was ar autopsy perform 1 Yes 2 n (Check only one me 5 Reside) 28d. Describe hore 28d. Location (Str. City or Town, and due to the cared at the time, da	23d. Date Mon acco use contril s 2 No de Control s 3 No de Control s 4 No de Control s 5 No de Control s 6 De Control s 6 De Control s 7 No de Control s 7 No de Control s 7 No de Control s 8 No de Control s 9 N	Approximate Interval Between Onset and Death Onset and Death Onset and Death of delivery the Day Year bute to the cause of death of the Completion of cause and the Cause

Registrar

State egistrar NAR17 2009

9105 32. Registrar's Signature

DHMH 17 Rev 1/2001

09-01931 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 08217 Shawn Corey Cannady State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar Reg. No Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Shawn Corey Cannady March 8, 2009 Medical Examiner 2130 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Sinai Hospital Baltimore 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** Months Davs Hours 1978 Maryland Director 214-92-4027 2, Auq. 1X M 2 30 Yrs Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 X Yes 2 No N/A Baltimore Maryland Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene.
nnt: If item 27 is marked other than "natural", or items 33a or 28a.c elecrector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 USA 2865 W. Garrison Avenue Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black 2 Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married Married Yes 2 X No Specify: Black Widowed f Yes, Give Yea Yes 2 X No specify: Divorced Medical Examiner δ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DD NDT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Laborer Private Industry year 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) 4 Diane Frederick Rudolph Cannady event, Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2865 W. Garrison Avenue Baltimore, Md 21215 t: If item 27 is n other traumatic Diane Frederick / Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, 1 X Burial 2 crematory or other place) Cremation Removal from State Department of King Memorial Park 3/16/09 Woodlawn, Maryland Donation 5 Other Specify: 5 22. Name and Address of Facilit Chatman-Harris Funeral Home Signatur of Tuneral Service L 5240 Reisterstown Road Baltimore, Md 21215 Physician int I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a. Gunshot Wound of Head Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and The law requires that the death certificate be executed Physician/Medical UNPENDED e attending physician for use as the burial AMENDED Box 68760, IF FEMALE 23c. If ves, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions Division of Vital Records, P.O. contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? ✓ Yes 2 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 ✓ Inpatient 2 Other: ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 V Yes 28a. Date of Injury (Month, Day, Year) Mar 6, 2009 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: Subject shot by police Natural 2005 hrs Pending Yes 2 V No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide or Town, State) 2800 Block West Garrison Avenue, Baltimore, MD determined (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 9, 2009 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed [M 2. Registrar's Sign State Registra

DHMH 17 Rev 1/2001 DCME 2006

			For State State Registrar	of Maryland / De	epartment of Certificate of			iene _{eg. No.} 2009	08218
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	th Day Year	3. Time of Death
	/Medic		Joseph T. Carda				3	13 2009	
	Examin	er	4a. Facility Name (If not institution, give street and I			or Location of Death		4c. County of Deat	
			FRANKLIN Square Hosf 5. Social Security Number 6. Sex	7. Age (In yrs. last birtho		r If Under 24 Hrs.	8. Date of Birth	Baltiu 9. Birt	hplace (State or Foreign untry)
	Funeral Director		212-32-9940 1⊠M 2□F		Months Davis	Hours Min.	8. Date of Birth (Month, Day,	Year) 12,1937	untry) MD
	р		Usual Residence of Decedent				Jopes.	,,,,,,	
	urylan show	_	10a. State 10b. County MD Baltimore	10c. City, Town o	rLocation ddle Riv	or			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	Ba-f	Director		MI		<u> </u>			
	be filed within 72 hours after death with the Maryland ntal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Evaninar must be notified at	ģ	10e. Street and Number 7 Octant Way		10f. Zip Code	1220		0g. Citizen of What Co JSA	untry?
ک	eath	Funeral	11 Marital Status 12. Was De	cedent Ever in U.S.			cifv Yes or No-	14. Race - Ame	rican Indian.
0	fter d r iten	Fun	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes	5 2 □x No		Hispanic Origin? (Spe ban, Mexican, Puerto F	Ricán, etc.)	Black, White	e, etc.
>05 €. 5-0036	ral", o	<u>م</u> ا	3 ☐ Widowed 4 ☐ Divorced If Yes, Year or	Dates:	1 □ Yes 2 🔯 No	o Specify:		Specify: W	hite
5-0	72 hc	Completed	15. Decedent's Education (Specify only highest grade complete:	16a. D	ecedent's Usual Occi	upation e during most of workin ed)	g i	16b. Kind of Business/	Industry
ر 121	vithin ane. han f	ם		(1-4or 5+) Tr	fe. DO NOT use retir uck Driv	ed) er		Baltimor	e County
, E	filed v Hygie ther i		9th 17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, N	Maiden Surname)	
Cardarett	be d d	To Be	Thomas Cardarelli					Buckingh	am
S Z	shoul ind M inar	-	19a. Informant's Name/Relationship (Type. Print)					, City or Town, State, 2	Zip Code)
ಸ ⊼	ges 1 and 2 should it of Health and Mer if item 27 is marke or other traumatic		Virginia Cardarelli	/wife 7	Octant W	ay Baltin	nore MI	21220	
ore.	es 1 a of He fitem		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro	20b. Place of Di cemetery,	isposition (Name of crematory or other pl	lace) Da		20c. Location - City or	
Card timore,	Pages ment of ant: If its lury or o	i	4 □ Donation 5 □ Other (Specify)	Bayvi Bayvi	ew Crema	tory 3/18	3/09	Baltimor	e MD
Balt	permit. Pages Department of Important: If i any Injury or once.		21. Signature of Funeral Service Licensee	ery		y Funeral	Home	Ave. Bal of Essex	to. MD 21221
			23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause or	t caused the th. Do not	enter the mode of dy	ying, such as cardiac or	r respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	jocardial	Infac	cTion			Onset and Death
	/Medical Examiner	Ш	Due	b (or as a consequence of):					
	Examiner	Ļ	Sequentially list conditions	TN					
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	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as it	edical	29a. Certifier (Check only one) 1 CertifyIng Physician: To the and m						
	Vithi Volti	M	29b. Signature and title of certifier	1 UD		nse number	2	9d. Date signed (Month	n, Day, Year)
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1			30. Name and address of person who completed ca			000	1T-		2 -7
5	Sta	to	DR Jack Ko 9000 31. Date filed (Month Day, Year) 32	FRANKLIN Registrar's Signature	square	UK 13a	LIO N	nd 212:	> /
4	Sta Registr		31. Date filed WAR 1 7 2009	ye B. And	allad				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5:24 AM 2009 Charles Joseph Croghan March 16, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Stella Maris Hospice Timonium | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year April 19, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 3. 1924 Maryland **Funeral** 1**X** M 2□ F 220-18-2819 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2 X No Funeral Director Baltimore Timonium Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21093 514 Limerick Cir., Unit 404 12. Was Decedent Ever in U.S. Armed Forces? 1∰Yes 2 □ No If Yes, Give Year or Dates: ₩₩ II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 21215-0036 1 □Yes 2XXNo Specify: Specify: white 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene Important: If item 27 is marked other than any Injury or other traumatic event, Item Man Elementary/Secondary (0-12) College (1-4or 5+) 12 inesman, supervisor telephone company 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be should be 2009 Teresa Cavanaugh Vincent Croghan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 514 Limerick Cir., Unit 404 Timonium, MD 21093 Lucy Croghan/wife Pages 1 and 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State MARCH Green Mount CrematoryMar. 17,2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) permit. John O. Mitchell IV, Funeral Services of Dulaney Valley, 200 E. Padonia Rd. Timonium, MD 21093 P. A. e of Funeral Service Licenses mitchell Approximate Interval Between Onset and Death Po t1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) COLON CANCER . /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of): requires that the death certificate be executed that initiated events resulting in death) Last 68760, Due to (or as a consequence of): physician a s the burial-t as IF FEMALE: Vital Records, P.O. Box 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify). 1 ☐Yes 2 ☐ No CHARLES CROGHAN the detached 9 Unknown 9 Unknown p s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 s autopsy page certificate ! 1 □ Yes 2 X No Physician: rector, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral dir Certification: To ō 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After To the Hospital or Attending ..teno. ...ter death. ...ral Director: A** Division 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only 2 Medical Examiner: On the basis of example X Nurse Practitationer stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

Registrar DHMH 17 Rev 1/200 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SR. DOROTHEA MAHOLLAND, GRNP 2301. Date filed (Month, Day, Year)

32. Redistrar's Signature

2300 DULANEY VALLEY RD.

back

TIMONIUM, MD 21093

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DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

29c. License number

OCME

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

March 11, 2009

30. Name and address of person who completed cause of death (Item 23a)

rum

Assistant Medical Examiner

32. Registrar's Signature

29b. Signature and title of certifie

Donna M. Vincenti, MD

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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 14, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harvy Francis MP Baltimars Washington Medical Center	al or Attending Physician: The safter death. Lo linector: After this certificate bud in by the funeral director, page.	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Pending investigation 3 Suicide 6 Could not be 28a. Date of Injury (Month, Day, Year) 28b. 28b. 28c. Place of Injury - At home, fac.	utpatient 3 □ DOA Other: 4 □ Nursing Ho Time of lnjury M 1 □ Yes 2 □ No	me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Numb
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 08222 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 1²³ 200²9' Marie Davis 11:15 a^M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Catonsville Baltimore 4G Stayman Court | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | MAR 5, 1925 Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In vrs. last birthday 1 □ M 2 F 84 Pennsylvania 317-18-4279 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 ☐ Yes 2 🕅 No MD Catonsville Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4G Stayman Ct 21228 **TISA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Lighting Consultant Lighting/Electrical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Harold Grounds Margaret Ley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim M. Mercier/daugher 400 Oak Ct Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 3/14/09 Baltimore, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee C. Todd Dring Cremation Society of Maryland, Inc. 299 Frederick Rd Baltimore, MD 21228 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Immediate Cause (Final In medical disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to for as a conse mence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant et time of death
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Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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Director

Funeral

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Completed

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Nextical Examble to other traumatic events.

Baltimore, Maryland 21215-0036

Examiner Physician/Medical

burial-tran attending physician for use as the buria signed by the a cate has been signal page 2 should b certificate funeral After t

Hospital or Attending Physician: The law requires that the death certificate be executed

after death. filled in by 24 hours a completely

within 2.

Division of Vital Records, P.O. Box 68760,

29b. Sign

State Registrar

7	Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
ם ס			1 Kes 2 No 3 Probably 4 Unkno
complete			24a. Was an autopsy performed? 1 \(\text{Yes} \) 2 \(\text{ANO} \) 24b. Were autopsy findings availar prior to completion of cause death? 1 \(\text{Yes} \) 2 \(\text{ANO} \) 1 \(\text{Yes} \) 2 \(\text{ANO} \)
ĕ	25. Was case referred to medical	26. Place of Death	(Check only one)
0	examiner?	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hor	ne 5 Residence 6 □ Other (Specify)
ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year) Injury Work?	8d. Describe how injury occurred
ertific	3 ☐ Suicide 6 ☐ Could not to determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
lical		hysician: To the best of my knowledge, death occurred at the time, date and place, miner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	

29c. License number DZ3365 29d. Date signed (Month, Day, Year) March 13, 2009

Frederich Rd. # 202, Balfimors, MO21228

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Month March 12, Antanas Drazdys 11:15A ^M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 12180 Woodford Drive Marriottsville Howard 7. Age (In yrs. last birthday) 93 Yrs. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Numbe 9. Birthplace (State or Foreign Days 1**X** M 2□ F 09/05/1915 Lithuania 219-30-5595 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Howard Marriottsville 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 12180 Woodford Drive 21104 Lithuania Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married 1 □Yes 2X No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator 12 Domino Sugar Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jurgis Drazdys Adele Tomosiute 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aldona Pilius - Daughter 12180 Woodford Drive Marriottsville, Maryland 21104 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 XOther (Specify)Entombment 03/18/2009 Baltimore, Maryland 22. Name and Address of Facility
David J. Weber Funeral Homes P.A. 21. Signature of Funeral Service Licens 5311 Fdmondson Avenue Baltimore, Maryland 21229 23a. Part. Enter the disease, or complic shock, or heart failure. List only on is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) ancor Due to (or as a consequence of): Sequentially list conditions, it cays. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
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4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 'n

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, Item once.

Physician

/Medical

Examiner

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Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It e Modical Examiner must be notified at

72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Records,

Division of Vital

Examiner b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-trar þ

hysician/Medical

ed by P	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the underlyin	g cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 □ Probably 4 □ Unknown			
Complete					24a. Was an autopsy performed? 1 \(\text{Yes} \) 2 \(\text{Yes} \) 1 \(\text{Yes} \) 2 \(\text{No} \) 1 \(\text{Yes} \) 2 \(\text{No} \)			
8	25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)			
2	1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 □	DOA Other: 4 Nursing	Home 5X Residence 6 □Other (Specify)			
ation:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28d. Describe how injury occurred				
Certifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, street, fac fy)	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
dical	29a. Certifier (Check only one) 12 Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier (Check only one) 29a. Certifier (Check one) 2	sician: To the best of my knowner: On the basis of examination and manner stated.	red at the time, date and plaction, in my opinion, death occ	ice, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)				
Me	29b. Signature and title of certifier	. Girgs		29c. License number 031726	29d. Date signed (Month, Day, Year) 316 2009			

Catonsville, Maryland 21228

To the within 2

State Registrar Dr. Girgis

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

724 Maiden

Choice Lane Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician MARCH 10, 2009 9:16PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Joseph Medical Center Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Funeral Months Days Hours Min 1 □ M 2 🛣 F Director death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examinat must be molified at Director 1 Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 Yes
If Yes, Give
Year or Dates: Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes No à Specify Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Father's Name (First, Middle, Last, Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Method of Disposition Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARDIO-RESPIRATORY ARREST disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** SEPTIC SHOCK Sequentially list conditions ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit law requires that the death certificate be executed and END STAGE RENAL DISEASE Due to (or as a consequence of): P.O. Box 68760, Physician/Medical PERIPHERAL VASCULAR DISEASE the as attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy ф Month Day Year 5 ☐ Other (specify) the ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ CORONARY ARTERY DISEASE 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? icate has t ; page 2 s 24a. Was an autopsy Hospital or Attending Physician: The this certificate Division of Vital 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1∐ Yes 21X No 1 npatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury After 28b. Time of 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending n 24 hours after death.

ne Funeral Director: A
bletely filled in by the fu death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

State Registrar

DHMH 17 Rev 1/2001

completely

within 2

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAR17

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7621

egistrar's Signature

29c. License number

D 30263

OSLER DRIVE TOWSON MARYLAND 21204

29d. Date signed (Month, Day, Year) 3-10-00

09-01926 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene Forrest Dotson 2009 08225 1- For State Certificate of Death Reg. No Registrar 3. Time of Death 1. Decedent's Name (First, Middle,Last) 2 Date of Death Physician/ Month Day March 7, 2009 1724 hrs Forrest Linden Dotson **Medical Examiner** 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death N/A Raltimore Sinai Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Numbe 6. Sex If Under 1 Year If Under 24Hrs. **Funeral** 51 232-94-9731 Months Davs Hours 195 7 Country Virginia 18, Director Apr. 1 X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Baltimore N/A 1 X Yes 2 No Maryland 3 the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? notified at USA 21215 3129 . Woodland Avenue 238 with Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. death 1 X Never Married 2 Yes 4 Specify:Black If Yes, Give Year after Yes 2 X No specify: 3 Widowed 4 Divorced "natural" ξ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done within 72 hours Completed during most of working life. DO NOT use retired) Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filted within 72 hos
Department of Health and Mental Bygiene
Important: If item 27 is marked other than "na
injury or other transmatic event, the Medical Ex-Elementary/Secondary (0-12) College (1-4 or 5+) Race Track Groom 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Forrest Linden Dotson, Sr. Mary Hart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code), Md 2406 Loyola Northway Apt. 11 Baltimore, Md 21215 19a. Informant's Name/Relationship (Type, Print) Mary Dotson/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State crematory or other place) X Burial 2 Cremation 3 Removal from State Dundalk, Maryland 3/14/09 Trinity Cemetery Donation 5 Other Specify: ^{22. Name and Address of Facility} Chatman-Harris Funeral Hom 5240 Reisterstown Rd Baltimore, Md 21215 22. Name and Address of Facility 21. Signature Funeral Service Licensee art I. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only she cause on each line. Approximate Interval **Physician** Between Onset and /Medical Death Narcotic intoxication Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical 23a,27,28a-f, perME, g889 3/18/09 TT physician a X UNPENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 V No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: Division of Vital Be examiner? Other DOA Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 his 1 🗸 Yes ۵ No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? After 27 Manner of Death Certification: 1 unk Natural Yes 2 X No death. Director: d in by the f Pending 3/7/09 unk 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) Unk 3 6 X Could not be Suicide or Town, State) unk (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical within 2 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registra

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Laron Locke MD. 31. Date filed (Month, Day, Year)

MAR17

and manner stated

Assistant Medical Examiner

Registrar's Signature

rlene

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

March 8, 2009

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Angela Drusilla Darrah 2009 March 09:00a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2932 4-H Park Road Centreville Queen Annes Co. If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗓 F 63 Director 216**-**54**-**3258 3, 1945 Maryland Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Ever, there must be notified at 1 ☐ Yes 2 No Maryland Queen Annes Co. Centreville Direct 10a. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2932 4-H Park Road 21617 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian 11. Marital Status Black, White, etc filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No altimore, Maryland 21215-0036 1 ☐ Yes 27 No Specify. Specify: 2 White 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than t National Security Elementary/Secondary (0-12) College (1-4or 5+) is 1 and 2 should be filed with Health and Mental Hygier tem 27 is marked other th 12 yrs. Clerk Agency 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael J. McMahon ပ္ Rose Marv White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tra Mr. Mark Darrah / Step Son 117 Granard Avenue Centreville, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 3/17/2009 Glen Burnie, MD 21. Signature of Funeral Service Lic 22. Name and Address of FacilitySingleton Funeral & Cremation Services PA; 1 2nd Ave SW, Glen Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami burial-transi P.O. Box 68760, 5 Due to (or as a co sequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗹 No Month Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 2 🗹 No 1 □ Yes 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury the Funeral Director: After the funeral birector of the function of the functi 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2540 CENTREVILLE ROAD CENTREVILLE MID 21617 \9 31. Date filed (Month, Day, Year) Registrar's Signa State Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	Marylar		artmen rtificat			ind M	_	giene (109	08227	
	Physici /Medic		Decedent's Name (First, Middle, Last MARGARET JEAN D AH	•	3						2. Date of Dea Month March	Day	Year 200	3. Time of Death 9 40pm	
-	Examir		4a. Facility Name (If not institution, give 1403 BOULDER CT.				HANC	OVER	Location o	f Deeth			inty of Death E ARUN	DEL	
	Funeral Director		5. Social Security Number 6. Se 095-43-0003	X	Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or F Country) APR. 16,1951 NEW YORK				
	a Maryland la-f ehow	ctor	10a. State 10b. County MARYLNAD ANNE ARUN	NDEL		ity, Town or Lo	cation	-,.,						10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
	ith with th	Funeral Director	10e. Street and Number 1403 BOULDER CT.				10f. Zip					10g. Citizen UNITE	of What Cou	•	
980	be illed within 72 hours after death with the Maryland Hygiane. Hygiane Hygiane of other than "netural", or items 23e or 28e-f ehow event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Force 1 ☐ Yes 2 2 If Yes, Give	1 ☐ Yes 2 🔯 No				Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify:				Race - Ameri Black, White acity: WH		
Maryland 21215-0036	d within 72 h plane. or than "netu the Wedeal	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	ication le completed) College (1-4o	r 5+)	16a. Deced (Give life. L HOMEM	kind of wor OO NOT us	l Occupa k done di e retired)	tion uring most	of workin	g .	16b. Kind of OWN H	f Business/Ir	ndustry	
ryland	2 should ba fila and Mantal Hy is marked othe aumatic svent,	To Be C	17. Father's Name (First, Middle, Last) ROBERT OSTROWSKI 19a. Informant's Name/Relationship (Ty	Dian.		40- 14-15-			HELEN	KRA					
e, Ma	1 and 2 s Haalth an em 27 is r ther traur		MARCUS D ARCANGELI		20h F	1403	BOULD	ER C	Т., Н	IANOV	ER, MAI	RYLAND	21076	6	
Baltimore,	permit. Pagas 1 and 2 should by Dapartman of Haalth and Manta Important: If item 27 is marked eny injury or other traumatic so once.		1 Depurial 2 Cremation 3 Removal from State Commeterly, Crematory or other place) MARCH 19, MEADOWRIDGE MEM. PK. 2009 ELKRIDG								DGE, M	- City or Town, State GE, MARYLAND			
g	Dapa Dapa Impo eny i		23a. Part1. Enter the disease, or compl	X.	ad the deet	KÎ 42	RKLEY 1 CRA	-RUD	DICK WY.,S	FUNE	RAL HON GLEN I	ME P BURNIË	A. MD 2		
^	Physician /Medical Examiner		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or a	Ce	4 Car	rcne		A		respiratory arr			Approximate Interval Between Onset and Death	
ρU,	ba axecuted clan and burlal-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	·	uence of):	131	t Me	ary	٩					
O. Box 6	the death carrify the attending ichad for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 🗌 Feta	ideath 3⊟i	Ectopic pre Other (spe	gnancy ecify)					23d. Date of delivery Month Day Year		
cords, P	er g	۵	Part II. Other significant conditions con	ntributing to death	but not res	ulting in the un	derlying ca	use giver	in Part I.		23e. Did tol			he cause of death?	
ם יו	25 2	Completed									24a. Was an autops perform	У	prior to con death?	opsy findings available impletion of cause of	
=	s cartil	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital:	iont a 🗆	ER/Outpatient	3□ DOA	Other			Check only on e 5⊠Reside				
	th. : Aftar thi		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D		28b. Time of Injury		c. Injury a		28	e 5 Aneside 8d. Describe ho			<i>y</i>)	
	within 24 hours after death. To the Funeral Director: After this cartificate he completely filled in by the funeral director, page	Certification	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir building, e	njury - At ho tc. <i>(Specif</i>)	ome, farm, stre	et, factory,	office		28	8f. Location (St. City or Town	reet and Nun , State)	nber or Rura	al Route Number,	
	n 24 hour he Funera plataly filis	Medical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	sician: To the bes ner: On the basis and manner s	of examinal	wledge, death tion and/or inve	occurred a estigation,	t the time in my opir	, date and nion, death	place, an	d due to the ca at the time, da	use(s) and nate and place	nanner as st a, and due to	lated. the cause(s)	
)	with To t	Σ	29b. Signature and title of certifier	w>	_ ^	ND		License r		96	29	on Car	ied (Month,	Day, Year)	
	ļ.		30. Name and address of person who con	mpleted cause of 18	death (Item	23a) (Type, P	rint)	Roa	d 10	3.0	h Glen Bu	meo o	Wa	106	
	Stat Registra	-	31. Date filed (Month, Day, Year)		rar's Signa	A L	الداور								

DHMH 17 Rev 1/2001

D Arcangelis

Mongaret

Please Type or Print in Black Indellble Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Co 8457AH Month Year Dey ARhes 2009 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Baltimore Reisterstown Future Care If Under 1 Year If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Days Hours Months 1⊠M 2□ F Yrs. 64 Jan.7, 1945 Maryland 214-76-7385 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☒ No Reisterstown Maryland Baltimore 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street end Number 21136 12020 Reisterstown Road USA 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Detes: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled None 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Louise Lamson Charles Garrett Dasch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) Brother 10674 Aspen Place; Union, Kentucky Elmer Dasch 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Date 1 ₺ Buriel 2 □ Cremation 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 3/16/09 Lorraine Park Cemetery Woodlawn, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licenses M01490 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disees or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Due to (or es a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was en eutopsy performed? 2240 1 ☐ Yes 2 ☐ No 1 Tes 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Residence 6 Other (Specify) 3□ DOA 2 ER/Outpatient 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injun 5 Pending 1 ☐ Yes investigetion 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Physician/Medical Examiner attending physician and for use es the bunal-transit Hospital or Attending Physician: The law requires that the death certificata be executed Division of Vital Records. P.O. Box 68760. Completed by director, Be 2 this funaral Certification: Director: After hours efter death. à To the Hospital within 24 hours e To the Funeral C edicai

Physician /Medical

Examiner

Physician

/Medical

Directo

Funeral

\$

Completed

Examiner

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Meryland Department of Health and Mantel Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Madical Examiner must be notified at ences.

Baltimore, Maryland 21215-0020

25. Wes case referred to medicel examiner? 1 | Yes 2 | 3-14(o 27. Menner of Death Natural 2 ☐ Accident 3 ☐ Suicide 4 Homicide

29a. Certifier (Check only one)

Kaymand

1⊠ Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D4768

29b. Signature end title of cartifier

31. Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year) 29c. License number

3/11/09

Mille MD 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

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State Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) . ^{Day} 2009 March 9, **Physician** Ε. Deuchler 6:10 р Charles /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Washington Medical Center Anne Arundel Glen Burnie If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1X□M 2□F 705-09-3083 1917 Maryland Oct. 6, Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State r than "natural", or items 23a or 28a-f show Anne Arundel Glen Burnie 1 ☐ Yes 2√No Director Maryland 10f Zin Code 10g, Citizen of What Country? 10e. Street and Number USA 21061 712 Broadview Blvd Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐¥Yes 2 ☐No If Yes, Give Year or Dates: WW I. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White 21215-0036 1 ☐Yes 2 ☐No Specify WW II 3₺ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fabrication Carpenter 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Deuchler Bealefeld George Η. Dora ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S of Health if Item 27 i Kevin Day (Per. Rep.) 210 Margate Dr., Glen Burnie, MD 21060 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or conce. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 3/13/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service License 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (of as a consequence of Examiner Ofma if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physician: The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 1 ☐ Yes 2 ☑ No 2 100 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1146 1 ☐ Yes 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 环 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and, manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tille of certifie 20 109 who completed cause of death (Item 23a) (Type, Print) Park Dreve Loft

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 08230 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician 3000 1:55 PM March Charles Arthur Eichler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ecil Maryland *metaye* Health Care KITTY Point 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Days Months Hours 88 June 17, 1920 Director 214-18-9133 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinar must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2 No Director MD Baltimore Catonsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21228 USA 3 Cedarwood Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Xi Yes 2 □ No 1942-If Yes, Give Year or Dates: 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married 1 □Yes 2 No Specify: þ 3 Widowed 4 NDivorced White 1945 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Officer <u>Shipyard</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur Otto Eichler Lillie Noves 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 331 South Justison St #517 Wilmington, DE 19801 Sandra Eichler/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 3/16/09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee C. Todd Dring 22. Name and Address of Facility
Cremation Society of Maryland, Inc.
299 Frederick Rd Baltimore, MD 21228 Locks, 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) inknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to minimize accause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 □ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No nours after death.
neral Director: / 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier W531 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Suresh Shandelva, MJ

(Month, Day,

MAR 1 7 2009

Baltimore, Maryland 21215-0036

Known To

Name

Division of Vital Records, P.O. Box 68760,

YA Maryland Hauth Care System
legistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month March 15 pay 2009 Robert C. Eberling 7:39 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Towson Baltimore County 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 19, 1919 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 89 Baltimore, MD. 220-03-6503 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10h. County 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Inc Medical Examinar must be notified at 1 ☐ Yes 2 No Director Lutherville Maryland Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 8409 Macauley Court United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 No 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Completed by Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Draftsman Architectural 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert C. Eberling, Sr. Lena Klemer ဂ 19a. Informant's Name/Relationship (Type. Print) (wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Patricia (nee Sprules) Eberling 8409 Macauley Court Luherville, MD. 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 16, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel 4 □ Donation 5 □ Other (Specify) 2009 Forest Hill, Maryland 21. Signature of Funeral Service Licenses Peaceful Alternatives Funeral&Cremation Ctr.,P.A 2325 York Road Timonium, Maryland 21093 Timonium, Maryland 23a. Part 1. Enter the diser's s, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest elock, of heart failly e. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician KINSON /Medical Due to (or as a consequence of) Examiner provascula if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine s been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Prostato 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an this certificate has be all director, page 2 s performed: 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Tes 2 Mo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral L 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Towscutown Blud 122 State Registrar

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, In 24 hour.

The Funeral Directory of the filled in by the completely within 2 To the

State

(Check only one)

29b. Signature and title of certifier

Kobert C. Doert CIM 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAR 1 7 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

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Registrar

DHMH 17 Rev 1/2001

29d. Date signed (Month, Day, Year)

Baltimere MD 212

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			State Registrar			Cer	tificate of	Death		Reg. No 2009 08233						
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	Examin	er								. City, Town, or Location of Death				4c. County of Death		
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	be filed within 72 hours after death with the Maryland tital Hygiene. Id other than "natural", or items 23a or 28a-f show event, I'm Medical Examiner must be notified at	by Funeral	11. Marital Status		Armed F		in U.S.	13. V	as Decedent of I Yes, specify Cub	Hispanic Original (1974) Dan, Mexican	igin? (Spe	cify Yes or N Rican, etc.)	No-	14. Race - Ar Black, Wh	merica	n Indian, c.
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${\cal N}$ altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	neral Service L	icense	2	<u> </u>		Name and Addre	ess of Facility	у		_		ICI &	
a spe	Pe E E S) //	11	Us X				Ruck	Towso	n Fu	neral	Home	, Inc.		
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	/Medical		resulting in death)		Due to	o (or as a con		-	1)		1	Τ,	grans
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Z	that led by deta	ا	Part II. Other signifi	cant condition	ns contributing to	death but not	resulting in	the un	derlying cause giv	ven in Part I.		23e. Did	tobacco u	ise contribute	to the	cause of death?
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₹ <u>₹</u>	Attending Physician: r death. sctor: After this certifica by the funeral director, p	9 Be	examiner?		Hospital:	Inpatient :	2 D EB/Out	nationt	3 DOA Oth			(Check only		c Act		haspice
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Ö	al or s afte	Certification: To	4 Homicide		build	aing, etc. (Sp	еспу)				165	City or To	own, State)		
5,	Hospital	g	29a. Certifier (Check only	Certifying	Physician: To the	ne best of my	knowledge	, death	occurred at the ti	ime, date an	nd place, a	and due to th	e cause(s)) and manner	as sta	ted.
M	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: /	Medical	one)	Z Medical E		nner stated.		2/01 1110	estigation, in my	opinion, dea	uii occuire	ed at the time	e, uate and	i piace, and di	ue to ti	nie cause(s)
_	50 Witt	2	29b. Signature and t	title of certifier	1				29c. Licens	se number	7			te signed (Mo	nth, Da	ay, Year)
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7			30. Name and addre			use of death ((Item 23a) (Type, P	rint)	/ .	(1-70-	TONS	11 11	110	~	/ 7 0:
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			State of Maryland / Department of Health and Mo	ental Hygier	¹⁶ 2009 08234
			Registrar Certificate of Death	Reg. P	3. Time of Death
	Physicia		Patricia Nell Elbert		Day Year
Marie,	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death
			13805 Ansari Lane 5. Social Security Number	9 Date of Birth	Baltimore Costs of Farriage
ı	Funeral Director		1 M 2 F Yrs Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	
	ъ		Usual Residence of Decedent	epi	
	harylau f shov	ō	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 □Yes 2 ☑ No
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	h with		13805 Ansari Lane 21013		U.S.A.
	r dear	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Forces) 15. Was Decedent of Hispanic Origin? (Specific Forces) 16. Was Decedent of Hispanic Origin? (Specific Forces) 17. Was Decedent of Hispanic Origin? (Specific Forces) 18. Was Decedent Origin? (Specific Forces) 18. Was Deceden	cify Yes or No- lican, etc.)	14. Race - American Indian, Black, White, etc.
36	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show cites! Examinational be notified at	by F	1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No Specify: 3 □ Widowed 4 □ Divorced Year or Dates:		Specify: White
21215-0036	72 hou natura lical E	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation	16b.	Kind of Business/Industry
121	J within 72 giene. r than "na ine Medi	mple	Elementary/Secondary (0-12) College (1-4or 5+)		
d 2	filed Hyg ther int,		17. Father's Name (First, Middle, Last) 4 Teacher 18. Mother's Name		ementry School en Surname)
Maryland	و قر ظ ه	To Be		ladvs	G. Vance
lary	2 shoul and M Is mar aumat	-	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural	J	
	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		Charles E. Elbert Husband 13805 Ansari Lane Bal 20a. Method of Disposition 20b. Place of Disposition (Name of Date Date Date Date Date Date Date Date	dwin, Mar	ryland 21013 Location - City or Town, State
nor	# O		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State		•
altimore,	# 본분분 .		On Name and Address of Faults		des Maryland Funeral Home, Inc.
m	permi Depa Impo any it			wson, Mar	
Н			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arrest,	Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death) a. Loomy OSARCOMA of 4+e(w)		22 4615
7	Examiner		Due to (or as I consequence of):		<i>O</i>
	pe tie	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
	xecute and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		
8760	cate be executed ohysician and the burial-transit	calE	d		
9	ertificating physics as the	Physician/Medical	IF FEMALE:		
Box	that the death certific ed by the attending p detached for use as t	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year
Ö	that the de ned by the a detached t	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		
ς, Р.	ss that gned b	by Pł	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
ord	w requires t s been signe should be			1 ☐ Yes	2 Probably 4 Unknown
Division of Vital Records,	0 10 0	Completed		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Ta	in: Th ifficate or, pag		25. Was case referred to medical 26. Place of Death	1 □Yes 24□1	
Ž	Physician: r this certific ral director, p	To Be	examiner? Hospital: Other:		6 ☐ Other (Specify)
n o	ng Ph (fter th ineral	on: T		3d. Describe how in	
sio	Attending r death. ector; Afte by the fune	icati	2 Accident investigation M 1 Yes 2 No	Of Location (Otropa)	D. I. D. A. N. S.
οi	at or A after i Direct d in by	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page		29a. Certifler (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	nd due to the cause	e(s) and manner as stated.
	the H thin 24 the F mplete	Medical	and manner stated. 29b. Signature And title of certifier / 7 29c. License number		Date signed (Month, Day, Year)
	5 w ti	-	D20929	250.1	2/17/09
,			39. Name and address of person who completed cause of death (Item 23a) (Type, Print)		0/1/0/
			131 Date filed (Month Day Year) 120 Consistency Stones to	Timpe 1	ND 21204
	Sta Registr		31. Date filed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	*	
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		-	State Registrar					Certi	ificate	e of	Death	7		Reg. N	No. 2 [109	082	35
	Physicia /Medic		1. Decedent's Name		Last) tta Ercol	ano							2. Date of D		jay,	= Y21 23	3. Time of De	
M. M.	Examin		4a. Facility Name (f not institution, J 0 5 e p	give street and nu	mber) al Cer	nter	,			r Location	OWS	on	4	tc. Count	y of Death Balt	imore	
	Funeral Director		5. Social Security N 123-24-48 Usual Residence of	i. last birtl		If Under Months	1 Year Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Bi (Month, D May 5,	rth ay, Yea 19	23	9. Birthp Coun Ne	lace (State or F try) W York	oreign			
-	2	H	10a. State	10b. County		10c C	ity, Town	or Loca	tion							10	Od. Inside City	Limite
:	a-f show	Director	MD	,	imore		rimor										1 □Yes 2	
	38	į.	10e. Street and Nu	mber					10f. Zip	Code				10g. (Citizen of	What Coun	try?	_
3	23a o		3 Glena	amoy Ct.	#202						093					USA		
-	ems	Funeral	11. Marital Status		12. Was Dec	edent Ever in l orces?	J.S.	13. Wa	as Deced	ent of H	lispanic O an, Mexica	rigin? (Span, Puerto	ecify Yes or N Rican, etc.)	0-		ace - Americ ack, White, e		
950	s I and z should be the ownthin 7.2 hours arter death with the maryand feath and Mental Hygiene. Health and Mental Hygiene. Them 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Evertinal must be notified at	ρ	Armed Forces? 1 □ Never Married 2 Married 1 □ Yes 2 Mo 1 □ Yes 2 Mo 1 □ Yes 3 □ Widowed 4 □ Divorced Year or Dates:					1 🗆	□Yes 2	No X	Specify	<i>y</i> :			Speci		ite	
	- 20	letec	15. Decedent's Education (Specify only highest grade completed)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					ing	16b. Kind of Business/Industry				
7 7	s 1 and 2 should be lied within f Health and Mental Hygiene. item 27 is marked other than other traumatic event, ITEMS	Completed	Elementary/Secondary (0-12) College (1-4or 5+) N/A					Homemaker					Own Home			Home		
2 :	othe	Be C	17. Father's Name	(First, Middle, L	ast)						18. Moth	ner's Nam	e (First, Middle	e, Maide	en Surna	me)		
<u>a</u>	s should be fried with and Mental Hygiene is marked other that aumatic event, Ire.	일	Vincenz	zo Pugl:	ia						M	laria	Corcio	Corcione				
	and sund		19a. Informant's N	ame/Relationsh	ip (Type. Print)		19b.	Mailing.	Address	(Street	and Num	ber or Rui	al Route Num	ber, City	y or Town	n, State, Zip	Code)	
1	and 2 ealth a n 27 is ner tra		Ronald N	4. Ercol	lano/Son							St.	#415 E	3alt	imor	e, MD	21218	
, ע			20a. Method of Dis	•		20b.	Place of cemetery	Disposit	ion (Nam	ne of ther plac	ce)	Marc	h 18,	20c.	Location	- City or To	wn, State	
ָ -	n. Pages Intment of Intant: If its Injury or o		4 ☐ Donation	5 ☐ Other (Sp		State Du. Mei	lanej noria	y Va 11 G	lley arde	ns		20			Ti	moniu	m, MD	
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w. Clary

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

SEPSIS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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POH LIM,

MAR 17 2009

31. Date filed (Month, Day, Year)

PNEUMONIA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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MARYLAND

Approximate Interval Between Onset and Death

Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093

Physician /Medical **Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical Completed by Be Certification: To

Medical

art Enter the disease, or conshook, or heart failure. List only

Immediate Cause (Fina

disease or condition resulting in death)

1 For State

	■ d				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of of 9 ☐ Unknown	al death 3 Ectopic	pregnancy specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not res	sulting in the underlying	cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death?
MULTIPLE MYELO)MA			1 ☐ Yes	2X No 3 Probably 4 Unknown
				24a. Was an autopsy performed 1 \(\sumeq\) Yes 2 \(\sumeq\)	
25. Was case referred to medical examiner?			26. Place of Dea	ath (Check only one)	
1 Yes 2 No	Hospital: 11 Inpatient 2	ER/Outpatient 3 🗆 🛭	OOA Other: 4 Nursing H	lome 5 Residence	6 ☐Other (Specify)
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	njury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		ome, farm, street, facto	ory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
29a. Certifier (Check only one)	hysician: To the best of my kno miner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigation	ed at the time, date and place on, in my opinion, death occu	e, and due to the caus urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
COL Cinnet of and Aid of any Aid of		2	On Lineago number	204	Data signed (Month Day Vear)

D 37254

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caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line.

Registrar DHMH 17 Rev 1/2001

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2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 08236 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2009 March 15. Mary Settle Ferguson 9:15 \mathbf{P}^{M} a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 11 Cedar Point Road Severna Park Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 24, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 😿 F Months Days Hours Min. 217-38-0777 94 1914 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 □Yes 2 No Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 Cedar Point Road 21146 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Booth Settle Nellie Kirk Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean K. Ferguson – daughter 11 Cedar Point Road, Severna Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc. 03/17/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Serger H, Williams Cremation Society of Maryland, Inc 299 Frederick Road, Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final an disease or condition resulting in death) Due to (or as a consequence of); Sequentially list conditions Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown ther significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

28a-f

23a or

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Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na any injury or other traumatic event there."

filed within 72 hours after

Baltimore, Maryland 21215-0036

event, the Medical Examiner must be notified at

Director

Funeral

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Examiner

Physician/Medical

Be Completed by

Certification: To

Medical

page 2 should funeral director. this After 24 hours after death Funeral Director: filled in by the

Physician: The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

Hospital or Attending

25. Was case referred to medical examiner?

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work?

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 28d. Describe how injury occurred

autopsy performe

1 □ Yes

1 □Yes 2 □No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b Signature and title of certifier 29c. License number

who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Dav. Year) MAR 17 2009

1 | Yes 2 | ■

5 Pending

Investigation

6 Could not be determined

Manner of Death

Matural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

2 No

State Registrar

completely

within 2.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08237 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death William Joseph Fisher, Jr. . 2009 March 16, 10:20 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1303 West 42nd Street Baltimore N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 31, 1921 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min. MD Country 1**X**M 2□ F 215-12-8325 87 Usual Residence of Decedent 10c City Town or Location 10a State 10h. County 10d. Inside City Limits MD N/A Baltimore XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1303 West 42nd Street 21211 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 120 Ages 2 □ No 1946 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married 1 ☐ Yes ZNo Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working Procurement Manager Elementary/Secondary (0-12) College (1-4or 5+) Armour Foods Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Joseph Fisher, Sr. Elizabeth Dettmer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary C. Fisher (Wife) 1303 West 42nd Street Baltimore, MD 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State **M**Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vet Cemetery 3/23/09 Garrison Forest, MD 21. Signature of Funeral Service Lic. 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Balto, MD 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner or Attending Physician: The law requires that the death certificate be executed

Department of Important: If it any Injury or conce.

Physician

/Medical

Examiner

Funeral

Director

s 23a or 28a-f show rust be notified at

Pages 1 and 2 should be filed within 72 hours after death with I nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or items ury or other traumatic event, the Medical Examina

3altimore, Maryland 21215-0036

Director

Funeral

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the Maryland

Physician/Medical Examiner physician and s the burial-trans attending pl for use as tl been signed by the should be detached Completed by certificate has birector, page 2 st funeral director, æ Medical Certification: To After this within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division of Vital Records, P.O. Box 68760,

Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Au atural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Nam and address of person pleted cause of death (Item 23a) (Type, Print) 01

8903 HARTER P BLL+ MARYERP 2.

State Registrar

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31. Date filed (Month, Day, Year) MAR 17

32. Registrar's Signature

Hospital

Physician /Medical Examiner
Funeral

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Baltimore, Maryland 21215-0036

Physici /Media Examir

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, Ex

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var —	Joseph	ine		Kenl	han							2. Date of D Month	eath D	ay	Year		ne of Death
	Social Security N	not institution Multin	n, give stre nedica 6. Sex	et and nu	mber) T. Age ('In yrs. la	st birthday)	4b. City, T	ion,	M L ff Under	21	204	irth.	c. Cou	altin	ath nore	tate or Foreign
U:	219-18-2 sual Residence of	Decedent	1 L M	2 ∏ F		84	Yrs.					3/3/1	1925			ARYĹAN	
	MD	10b. County BALT	IMORE		1		Town or Loc RKVILI							10d. tnside City Limit 1 ☐ Yes 2 ☐X			
ā	e. Street and Num 2901 CON		URT	APT.	С	10f. Zip Code 21234						10g. Citizen of What C USA				Country?	
by Fur	11. Marital Status 1 Never Married 2 Married 3XXVidowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:						If	Vas Decede Yes, specif	y Cuban	panic Or., Mexical Specify:	n, Puerto	ecify Yes or N Rican, etc.)	0-	E	Race - Am Black, Wh	erican India ite, etc. WHITE	
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iminer GOS ES	21s. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											Onset	Between and Death hs - Year us - Years				
₩ IF	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1												23d. Date of delivery Month Day			Year	
٠ ﴿	irt II. Other signifi Hyperter HypoYhej	1		uting to d	eath but r	not result	ting in the und	derlying cau	se given	in Part I			Yes 2	!□ No	3 □ P	utopsy findi	of death? Unknown Ings available of cause of
	. Was case referr	ed to medical		201					1		of Death	perf	ormed? 2 ⊒ No	5	death?		51 54U36 51
Certification; To	1 Yes 2 1 Manner Death 1 Natural 2 Accident 3 Suicide		ation not be	8a. Date (Mon	tnpatient of Injury th, Day Y	'ear) 2	R/Outpatient 28b. Time of Injury	M 280		4 (1411)	No	ne 5 Res 28d. Describe	how infl	iry occ	urred		Number
1	4 Homicide 9a. Certifier (Check only one)		Practit g Physicia Examiner:	build toner in: To the On the b	best of rasis of ex	ny knowl	ledge, death	occurred at	the time	, date an	d place, a	City or To	wn, Stat	e)	manner a	s stated	
	9b. Signature and			and man	ner state	J.			icense r							th, Day, Yea	
	30. Name and address of person who completed cause of death (flem 23a) (Type, Print)							R097104 3/16/09									

Amend #8 per FH g890 4/9/09 TT/#7perFH G890 4/22/09 WS State of Maryland / Department of Health and Mental Hygiene 0 9 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 9 2009 11:20 PM Fresta Donald March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Elkton Cecil 9 Circle Avenue If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) New Jersey 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days 1 X M 2 □ F Yrs 111/19/1963 149-60-1168 46 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modifiel Examinat must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 X Yes 2 No Completed by Funeral Director Elkton MD Cecil 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21921 U.S.A. 9 Circle Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Transportation 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Murray Fresta Virginia Menale 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Brookside Avenue, Laurence Harbor, NJ 08879 Virginia Swist/Sister 263 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 3/16/2009 Hanover, Maryland 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 7522 Connelly Dr., Ste.P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ina /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed nis certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 🗌 Ectopic pregnancy Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 es 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No this certificate 1 ☐Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steloy Elkton, MD 21921 W. High natrimin. 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 08240 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Danielle Fisher Erica 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Greneras HMOre 1 5. Social Security Number 6. Sex Year If Under 24 Hrs Date of Birth (Month, Day, Year) 9 12 Birthplace (State or Foreign Country) Months Min 1 □ M **3**⁄□ F Davs Hours 218-86-6618 Yrs. 34 09 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits NA Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 U.S.A. 1112 North Woodyear Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 XNever Married 2 ☐ Married 1 ☐ Yes 2 ☐ XNo Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Medical Assistant Wyman Park Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gayle Jones John C. Fisher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3621 Dolfield Ave, Baltimore, Md 21215 Gayle Lee-Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) King Memorial Park 3/20/09 Woodlawn, Md 21. Signature of Funeral Service Ligensee 22. Name and Address of Eacility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Juse (Final disease or condition resulting in death) Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

10a. State

MD

Examiner

Funeral

Director

r 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Motori Lean, in all 10 being Injury or other traumatic event,

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

Be

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Examiner

Physician/Medical

Completed by

Be

Medical Certification: To

31. Date filed (Month, Day, Year)

the Maryland

physician and s the burial-trans t by the attending patached for use as t signed by the a

The law requires that the death certificate be execute

To the Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760.

has certificate ! within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last	b. Allo Yi C Encland Due to (or as a consequence of): c	logaAry		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Cct 4 Pregnant at time of death 5 Ott	topic pregnancy ner (specify)		23d. Date of delivery Month Day Year
End Stage Ken	, , , , , , , , , , , , , , , , , , , ,	alysis,		use contribute to the cause of death?
Al	ngestive Heart Failure Ifusion	<u>ی</u>	24a. Was an autopsy performed? 1 □Yes 2 1/20 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?		26. Place of Deat	h (Check only one)	
1 Yes 2 No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3	Othori	ome 5 Residence	6 ☐ Other (Specify)
27. Manner of Death 1			28d. Describe how injur	
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, f building, etc. (Specify)	actory, office	28f. Location (Street ar City or Town, State	d Number or Rural Route Number,)
29a. Certifier (Check only one) 1 ✓ Certifying Ph 2 ☐ Medical Exam	ysician: To the best of my knowledge, death occ niner. On the basis of examination and/or investi and manner stated.	curred at the time, date and place, gation, in my opinion, death occur	and due to the cause(s red at the time, date and) and manner as stated. d place, and due to the cause(s)
29b. Signature and title of certifier	4 ~ 3	29c. License number	29d. Da	te signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

			1 - For State of Maryland / Depar	tment of Health and M ificate of Death						
			Registrar 1. Decedent's Name (First, Middle, Last)	Reg. 2. Date of Death	. No. 2 U U 9 U B Z 4 I					
	Physici /Medic	al	Jean Yvonne Ferguson 4a. Facility Name (If not institution, give street and number)	4h City Town as Lagation of Docto	March	14 2009 6 20 9 M				
	Examin	er	Doctors Community Hospital	4b. City, Town, or Location of Death Lanham		4c. County of Death				
	Funeral Director		578-52-4602 1□ M 2□XF 71 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 0 2 - 0 3 - 1	9. Birthplace (State or Foreign Country) 938 Wash DC				
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	ition		10d. Inside City Limits				
	a-f sho	ctor	DC Was	hington		1 □Yes 2 X No				
	th with the 23a or 28	Funeral Director	10e. Street and Number 1442 Bruce Pl. SE	10f. Zip Code 20020	10g.	. Citizen of What Country?				
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show dother than "natural", or items 23a or 28a-f show event, the Medical Examinar mast be notified at	by	1 □ Never Married 2 □ Married 1 □ Yes 2 【No	as Decedent of Hispanic Origin? (Spr /es, specify Cuban, Mexican, Puerto □Yes ৄ∕ □No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black				
2-0	72 hc "natur	letec	(Specify only highest grade completed) (Give ki	nt's Usual Occupation nd of work done during most of worki	na I	b. Kind of Business/Industry				
717	filed within 72 Hygiene. other than "na ent, the Medic	Completed		NOT use retired) Cook	Wa	shington Hospital Center				
	be filed ntal Hyg d other event,	To Be Co	17. Father's Name (First, Middle, Last)		(First, Middle, Maid	den Surname)				
Maryland	should be filed and Mental Hyg s marked other umatic event, i		Stanely Jones	Louise		inson ————————				
_	es 1 and 2 should of Health and Mer f Item 27 is marke ir other traumatic		Bernardette Simms/Daughter 1211		tol Hei	ghts, MD 20743				
	ë ° = 5		4 Donation 5 Other (Specify)	ns Cem. 03-25	5-09 Ch	c. Location - City or Town, State eltenham, MD				
Rail	permit. Pag Department Important: any injury o			Name and Address of Facility Ron 583 Middleport		lor II FH ite Plains, MD				
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death							
4	hysician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Ductor as a consequence of): Onset and Death Onset and Death							
	Examiner		Grand no Lext Lec							
17	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Due to for as a consequence of): Due to for as a consequence of):							
7	executed n and al-transit	xan								
8/60,	ficate be executed physician and s the burial-transit	dical	d							
•	ding p		IF FEMALE: 23b. We decedent regrent 23c. If yes, outcome of pregnancy							
0 0 0	owitine Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months? 1 Live birth 2 Fetal death 3 E	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year				
ν, Γ	s that gned b e deta	by Pt	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death?				
cords,	equire sen siç ould b		Carclingopathy		1 □ Yes	2 No 3 Probably 4 Unknown				
ě.	has by	Completed	Heart Failure		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of				
vital i	in; Th ifficate or, pag		25. Was case referred to medical		performed					
>	ysicia is cert directe	o Be	examiner? 1 Yes 2 No	26. Place of Death		e 6 ☐ Other (Specify)				
5	ng Ph kfter th Ineral	On: T	27. Manner of Death 1/☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury		28d. Describe how in					
VISION	ttendideath.	icati	2 Accident investigation	M 1 □Yes 2 □No	201					
<u>}</u>	al or A s after al Direct ed in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	, lactory, office	City or Town, St	t and Number or Rural Route Number, tate)				
7:	lo the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death of the basis of examination and/or investand manner stated.	ccurred at the time, date and place, a stigation, in my opinion, death occurred	and due to the caus ed at the time, date	e(s) and manner as stated. and place, and due to the cause(s)				
i	vithi To th	ž	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)				
			Diamo	MOD 31528	1110	nch 14 2009				
			30. Name and address of person who confipleted cause of death (Item 2da) (Type, Pri	the Ad Mhospels	mo	20785				
4	Stat		31. Date filed (Month, Day, Year) MAR 1 7 2009 32. Registrar's Signature	1	1111/	00101				
	Registra	ir	MAKI 1 2000 CERMAN 10. MARIE							

To the

31. Date filed (Mo State Registra

DHMH 17 Rev 1/2001

OCME 2006

29b. Signature and title of certifier

Ana Rubio MD.

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Registrar's Signa

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

March 14, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death Age (In yrs. last birthday, 5. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 220-12-966 1 M 2 □ F Months Days Min. Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinations ust be notified at 10a State 10b Count 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MAKYLAND 1 ☐Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S.
Armed Forces?
1 Mres 2 No
If Yes, Give
Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ 3 W Widowed 4 □ Divorced Specify: Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) UWOCK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 5150 KEYVIEW 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8800 HATEORD RD. PARKVILLE Sikaw 23a. Part1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or legit failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ASPIRation neumonia /Medical Due to (or as a consequence of): Examiner pharyng Cequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Dementia the attending physician and hed for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) 9 Unknown been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ icate has been sign, page 2 should b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed Yes 2 certificate 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Hospital: Other: 4 12 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 □Yes 2 □ No To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie (Check only one)

24 hours within 2 To the I

> State Registrar

31. Date filed (Month, Day, Year)

hwkwuma

29b, Signature and title of certifier

1124

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c, License number

D006190.

AWC nue

29d. Date signed (Month, Day, Year)

Bultimore MD 21221

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year Glenn Given Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner timore (/æ/€ ☐ If Under 24 Hrs. 8. Date of Birth (Month, Day, Youne 2, Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Birthplace (State or Foreign Country) **Funeral** . 1943 Months Days Min. Hours 212-42-1224 1 **X**M 2 □ F 65 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exprision on the traumatic event, the Medical Exprision on the control of the contr Baltimore Chase Director MD 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21027 USA 7229 Grace Quarters Road Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc 1XYes 2 ☐ No If Yes, Give Year or Dates: $\mathcal{C}^{d_i Ve \mathcal{N}_j} \qquad \mathcal{E}/e \mathcal{N} \mathcal{N}$ Baltimore, Maryland 21215-0036 1 Never Married 2 Married 1 ∐ Yes 2 La Wo White Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machinist ED K Machines 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Glenn Warder Given Madeline Pauline Jerscheid ဥ 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O.Box 541 Chase MD 21027 19a. Informant's Name/Relationship (Type. Print) Frances Given /wife 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial /2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 3/16/09 Baltimore MD 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Baltimore MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** artio disease or condition resulting in death) minutes /Medical Due to (or as a consequence of): Examiner Esqueritally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760 physician Physician/Medical the as t attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. the detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>a</u> icate has been signated by page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform certificate Division of Vital 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifie 1 🗜 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed //

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760.

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of Vital

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Yin Oung,

8022 Belair Road

M.D.

29c. License number

D0017728

29d. Date signed (Month, Day, Year)

March 16, 2009

Baltimore, Maryland 21236

and manner stated

32. Registrar's Sigrature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State	State of	Marylan	•	artment of I		and M	ental Hy	giene	100	0021.6
			Registrar 1. Decedent's Name (First, Middle,	Last		Cel	rtificate of	Death		0. D-1(D-	Reg. No. 💪 👢	103	00240
	Physici		Robert Thomas				2. Date of De Month	Month MARCH 14 2009 06:20 F 4c. Country of Death N/A 8. Date of Birth (Month, Day Year) July 19,1947 9. Birthplace (State or Ford Country) Mary Iand 10d. Inside City Lim 1					
	/Medi Examir		4a. Facility Name (If not institution,	give street and numb	per)		4b. City, Town, o	or Location o		MACAI			100720
	- A		ST. AGNES A	HOSPITA	<u></u>			TIM					
	Funeral Director		214-50-4894	3. Sex 7 1 🕅 M 2 □ F	Age (In yrs. 61	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da July 1	th ay, Year) 19,1947	Cou	ntry)
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	the Maryland 28a-f show	ţō	Maryland Balti	more		alethor							1 □Yes 2 🙀 No
	h the	irec	10e. Street and Number	MOT C	110	11001101	10f. Zip Code				10g. Citizen of	What Cou	ntry?
	th with	a D	1704 Summit Ave	nue				2122	7		Unit	ed St	tates
	er death with titems 23a or	nue	11. Marital Status	12. Was Decede	es?	S. 13. \	Was Decedent of h	lispanic Orig	gin? (Spec	cify Yes or No lican, etc.))- 14. Rac Bla		
9	aff o	d by Funeral Director	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 [X]Yes 2 If Yes, Give Year or Date	□ No es:		1 □Yes 2 🙀 No	Specify:					
L	72 hg	etec	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	dent's Usual Occu kind of work done OO NOT use retire	pation during most	of working	g	16b. Kind of B	usiness/In	dustry
Ş	within ene.	Completed	Elementary/Secondary (0-12)	College (1-4							Commo	a+i a=	. Foodlike
7	filled Hygin	ပိ	17. Father's Name (First, Middle, La	_		Juv	enite ke						racility_
	figity in a Communication of the communication of t	To Be	Harlan Emerson	Grace				Eliz	zabet	h Lill	ian Fel	dman	
	Niary jand 21215-0035 nd 2 should be filed within 72 hours aft tith and Mental Hyglene. 27 Is marked other than "natural", or r traumatic event, Its Modical Evan		19a. Informant's Name/Relationship Betsy Ann Krame		er	1	-						,
!	s 1 ar of Hea	-	20a. Method of Disposition		20b. P		sition (Name of natory or other pla		Da				
	Page nent c unt: If		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from Stacify)	ale I		Cremator		3/19	/2009	Glen B	urnie	, Maryland
2	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any nijury or other traumatic event, its Mcdical Exponse.		21. Signature of Funeral Service Li		'	72	. Name and Addre	ess of Facility	Gary Boul	L. Ka	ufman F Elkrid	unera	l Home, Inclaryland,210
-			23a. Part 1. Enter the disease, or c shock, or heart failure. List or	mplications that cau	sed the death								Approximate Interval Between Onset and Death
S	Physician		Immediate Cause (Final disease or condition	a.		HYT	ALMH						Onset and Death
	/Medical Examiner		resulting in death)		as a consequ	•			2				
HOMA		ja l	Sequentially list conditions,	D.	as a consequ		ARTER	4	DIS	SEAS	E	1	O Y EARS
2 12	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	_	30 11 00110040	.0.100 01,7							
	an an rial-tra		resulting in death) Last	Due to (or	as a consequ	ence of):		_					
' (icate be executed physician and sthe burial-transit	dical		d									
(X OX	/Mec	IF FEMALE:	220 If you outoo	ma of progna	nou		-					
7	death certife attending do for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		me of pregna th 2□ Fetal nt at time of d	death 3	Ectopic pregnand Other (specify) _	су				te of delive onth	ery Day Year
7 5 1	the d	ysi	1 □Yes 2 □ No 9 □ Unknown	9 🗆 Unknow		50.	Tottler (specify) _						
02	us, r.O. box of ires that the death certific signed by the attending I be detached for use as		Part II. Other significant condition	s contributing to deat	h but not resu	ilting in the un	nderlying cause giv	en in Part I.		23e. Did to	obacco use cont	ribute to th	ne cause of death?
0	iaw requires that the as been signed by the 2 should be detache	led	DIABETES N	NELLIT	US_	TYP	ETW	0		1 🗆 1	Yes 2 No	3 ☐ Prot	oably 4 🗆 Unknown
	as b	Completed by	SARCOIDO	515						24a. Was	an 24b. osy rmed?	Were auto prior to co death?	psy findings available mpletion of cause of
	VICAL I sician; Th certificate irector, pa		CHRONIC F 25. Was case referred to medical	RENAL	FA	LILU	RE			1 □ Yes	2 X No	1 ☐ Yes	2 □ No
	Physician; This certific	o Be	examiner?	Hospital:	atient 2 🗆 I	FB/Outnatien	t 3 DOA Oth			(Check only o	<i>ine)</i> dence 6 □Oth	or (Consider	
		Ë	27. Manner of Death	28a. Date of		28b. Time of Injury	28c. Injui				now injury occur		y)
2	Attending r death. ector: After by the funer	atic	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	tion			M 1 🗆	Yes 2□N	lo				
5	LIVISION I or Attending after death. Director: After d in by the fune	Certification: To	3 Suicide 6 Could no 4 Homicide determin	ed 28e. Place of building	Injury - At ho , etc. <i>(Specify</i>	me, farm, stre	eet, factory, office		28	3f. Location (S City or Tov	Street and Numb vn, State)	er or Rura	l Route Number,
	To the Hospital or Attenc within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) CertifyIng 2 Medical Exponents	Physician: To the be caminer: On the bas and manne	is of examinat	wledge, death tion and/or inv	occurred at the ti	me, date and opinion, deat	d place, ar h occurre	nd due to the d at the time,	cause(s) and modate and place,	anner as s and due to	tated. the cause(s)
	To the Mithin Fo the	Me	29b. Signature and title of certifier	and manner	Jidiou.		29c. Licens	e number			29d. Date signe	d (Month,	Day, Year)
			JKathle	itsnik	le.	MA	PS	2374	47		MARCH	14	2009
	12		30. Name and address of person w	no completed cause	of death (Item	23a) (Type, F		. 0 !	<u> </u>	/	-into	, 7	2001
	,						ATON AL	ENUE	BAL	TIMOR	E, MAR	YLAN	JD, 21229
	Sta Registr		31. Date filed (Month, Day, Year)	000	istrar's Signat	, pa	Kel						
			44 A FD 4 17 12	THE 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		1.0							

DHMH 17 Rev 1/2001

1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** GOLOSKOV MESHALIN March /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Greater Baltimore Medical Center Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month Day Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 X M 2 □ F Days 85 217-18-9331 Director Usual Residence of Decedent 10c. City. Town or Location 10a State 28a-f show d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, if a list standing at the contact of the contract of the GOLOSKOV, MESHALIN Director BALTIMORE BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Numbe 21204 1 SMETON PLACE, APT, 1303 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No WW I If Yes, Give Year or Dates: ARM Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status WWII 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 □ Yes 21X No Specify: ARMY 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) CORPORATE PRESIDENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GOLOSKOV ROSE SANDER ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau once. 9 BRIDLE COURT, REISTERSTOWN, MD NATHAN GOLOSKOV / SON 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BETH EL MEMORIAL PARK 03/16/2009 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or co shock, or heart failure. List on

Physician /Medical Examiner

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

Immediate Cause (Final disease or condition resulting in death)

1 - For State Registra

	tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line.	Approximate Interval Between		
- a	Stroke	Onset and Death		
	Due to (or as a consequence of):			
b	Ventricular tibrillation			
D	Due to (or as a consequence of):			
С				
	Due to (or as a consequence of):			
d				

Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Physician/Medical þ Completed

Be

Certification: To

Medical

Box 68760,

Division of Vital Records, P.O.

23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 9 Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 9 Unknown

3 - Ectopic pregnancy 5 ☐ Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

23e. Did tobacco use contribute to the cause of death?

Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

23d. Date of delivery

Month

24a. Was an autopsy performed 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 □ No

Small howel resetion 25. Was case referred to medical examiner? 1 Yes 2 No

Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

27. Manner of Death 1 Natural 2 Accident 3 Suicide

4 Homicide

5 Pending investigation 6 ☐ Could not be 28a. Date of Injury (Month, Day, Year)

28b. Time of 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Reg. No. 20

2009

Baltimore

USA

14. Race - American Indian,

COLLECTIONS

KOVLER

WHITE

Black, White, etc

10:40 P M

9. Birthplace (State or Foreign Country) MD

10d. Inside City Limits

1 ☐ Yes 2 No

29a, Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

adhesions

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

35 Gosne Mark 31. Date filed (Month, Day,

32. Registrar's Signature

State Registrar



State of Maryland / Department of Health and Mental Hygiene ? 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dav Year Alice Humes 9.45 PM 2009 MARCH /Medical 13 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOSPITAL SAINT AGNES BALTIMORE N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Feb 22, 1 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🗓 F 004-22-2958 8() Yrs. Director 1929 Maine Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Wedical Evandone must be notified at Director 1 ☐ Yes 2 No Maryland Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 2209 Arapahoe Avenue Funeral USA filed within 72 hours after death 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify ģ White 3 ☐ Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Clerical Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental ဥ Oswald Hammond Marjorie Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter Humes, Son permit. Pages 1 and 3 Department of Health Important; If Item 27 any injury or other tr once. 2209 Arapahoe Avenue Catonsville, MD 21228 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 03/17/09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of thingeral Service Licensee

Thomas Gregor Cremation Statety Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Immediate Cause (Final Physician ACUTE disease or condition resulting in death) DAYS /Medical Due to (or as a consequence of): Examiner PNEUMONIA DAYS Sequentially list conditions, if any lamin list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner as a nonsectionne of law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): P.O. Box 68760. the attending physician the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Physician; The certificate Vital 2 X No 1 □ Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specity) 1 Yes 2 No ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA o 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; Division or Attending 1 Natural 5 ☐ Pending Investigation 2 Accident 1 ☐ Yes 2 ☐ No after death Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Despite K. Vishnu P 20 998 MARCH 13, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VISHNUDEEPIKA EVULT, 900 S. CATON AVE, BALTIMORE, MD - 21229 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 1146 A. M Clayton Henry Huddle March 15, do09 Eacility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death AMAI 8. Date of Birth April 1 Day 7,1919 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Security Number 1₽ M 2□ F Months Days Hours Min. Zan Etten, N.Y. 057-14-9082 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A 1-Yes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5405 Biddison Ave. 21206 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) +2 Design Engineer Maryland Cup Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fred C. Huddle Lena Hollenbeck 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Virginia Cowles (Sister) 101 Center Street Waverly, New York 14892 Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place)

4 Donation 5 Bother (Specify) entombmen

20c. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cem. 20a. Method of Disposition Date 20c. Location - City or Town, State 19, March 2009 Rossville, Maryland Service Licensee Peaceful Alternatives Funeral&Cremation Ctr., P.A. 23a. Part 1. Infert Indicated a complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, is only one caudi on each line.

See U

District. avo. Timonium, Maryland 21093 Approximate Interval Between Onset and Death Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events Due to (or as a consequence of). resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? tem son 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide **Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

Examiner physician and the burial-transit 68760, Box o σ. Division of Vital Records, ō

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, II = Medical Examinating to profilled at

Physician /Medical

Examiner

Physician/Medical

2

Completed

Medical Certification: To Be

Baltimore, Maryland 21215-0036

/Medical

attending p s been signed by the should be detached certificate has birector, page 2 sl After this certification funeral director, I thours after death.

uneral Director: A

ely filled in by the fu No the within 24 hours after until 24 hours after until 24 hours after until 25 the Funeral Direct

> State Registrar

31. Date filed (Month, Day, Year) MAR 1 7 2009

29b. Signature and title of certifier

(Check only one)

29c. License number

Dol8 230

29d. Date signed (Month, Day, Year)

Good Samantan Horfetal, MD 21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHASHIDHARAN

DHMH 17 Rev 1/2001

State

Registrar

HAMILTON

NANCY

32 Registrar's Signature

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

SR. DOROTHEA MAHOLLAND, CRNP

MAR 17 2009

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 7:10 P. Mary F. Herlihy 2009 March 13. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Gilchrist Hospice Baltimore Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex Days Hours 1 □ M 2□7F 152-48-6829 55 Yrs June 8, 1953 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location Maryland N/A1∑Yes 2 No Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 5709 Greenleaf Road 21210 of America Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☒ No white Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+)_ Elementary/Secondary (0-12) Administrator U.S. State Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward R. Fickenscher Jane Schulte 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5709 Greenleaf Road Baltimore, Maryland 21210 Mr. Mark F. Herlihy/ husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 15. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Exausı Euneral 2009 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A.
2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licensee Approximate
Interval Between
Onset and Death
Mouths 23a. Part 1. Enter the disease, or complicat insithat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, in the light immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a conse uence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death ise contribute to the cause of death? No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 6 Other (Specify) HOSPIC occurred d Number or Rural Route Number,

/Medical Examiner 200 physician and s the burial-trans 90 687 attending phase as the Box is certificate has been signed by the director, page 2 should be detached o Records, Vital ot Division Hospital or Attending

Physician/Medical þ Completed Be Certification: To within 24 hours a Medical

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

Be

ed other than "natural", or items 23a or 28a-f shorevent, the Medical Examiner must be notified at

within 72 hours after

and Mental Hygiene. Is marked other than

Department of Health ar Important: If item 27 Is any injury or other trau

Physician

Baltimore, Maryland 21215-0036

9 🗆 Unknown		9 🗆	OTKHOWIT								
Part II. Other significant o	conditions co	ntributing	g to death but not res	ulting in the unde	erlying ca	ause given in	Part I.		23e. Did tobacco us 1 ☐ Yes 2 ☐	se contribute to to	
									24a. Was an autopsy performed? 1 □Yes 2 No	24b. Were autoprior to condeath? 1 □ Yes	ompletion of ca
25. Was case referred to I	medical	26. Piace of Death (Check only one)									
examiner? 1 ☐ Yes 2 No	Ī	Hospital:	1 ☐ Inpatient 2 ☐	ER/Outpatient	3 🗆 DC	Other: 4	☐ Nursing H	łome	5 ☐ Residence 6	Other (Speci	ity) HOSPI
2 Accident	Pending investigation		Date of Injury (Month, Day, Year)	28b. Time of Injury	M 2	8c. Injury at Work? 1 □ Yes	2 🗆 No	28d.	Describe how injury		
3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e.	Place of Injury - At h building, etc. (Speci	ome, farm, street	, factory	, office		28f.	Location (Street and City or Town, State)	Number or Rur	al Route Numb
		iner: On							due to the cause(s) at the time, date and		

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 555W. Towsatown Blud/Bacto MD Dendal R Faulthernd

Date filed (Month, Day, Year)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

			, For	State of Maryland	/ Department of H	ealth and Me	ntal Hygien	e	
			2009	08252					
-	Physicia /Medic Examin	an al	1. Decedent's Name (First, Middle, Las OCO + Middle, Las 4a. Facility Name (If not institution, live	Mildred	Hager 4b. City, Town, or	n	Date of Death Month	A 2009 c. County of Death	3. Time of Death
, and	Examin		union Hox	spital	EIK	ton		Ceci	
	Funeral Director		5. Social Security Number 6. Security Number 11 Usual Residence of Decedent	7. Age (In yrs. las	t birthday) If Under 1 Year Months Days	Hours Min. 8.	Date of Birth (Month, Day, Yea OV. 4		ace (State or Foreign try) more, mo
	ith the Maryland or 28a-f show	ctor	10a. State 10b. County	10c. City, 7	Town or Location X FOX			10	od. Inside City Limits 1 ☐ Yes 2 ☑ No
	ath with the 23a or 28 ust by no	Funeral Director	320 Oak R	∞ d	10f. Zip Code	363		O.SA	ry?
9036	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show haddeal Evar, instruust be calified a	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 D Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 ☑ No	spanic Origin? (Specif n, Mexican, Puerto Ric Specify:	y Yes or No- an, etc.)	14. Race - America Black, White, e	
21215-0036	vithin 72 hours ene. than "natural",	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		16a. Decedent's Usual Occupi (Give kind of work done of life. DO NOT use retired	luring most of working	16b.	Kind of Business/Ind	lestry Leme
CA	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Item.	To Be Co	17. Father's Name (First, Middle, Last)	enh Proper		18. Mother's Name (F	First, Middle, Maide	en Surname)	
, Maryland	permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natu any injury or other traumatic event, I'm Madical once.	ĭ	19a. Informant's Name/Relationship, (7	voe. Prince	19b. Mailing Address (Street a	and Number or Rural F	Route Number, City	or Town, State, Zip	Code)
altimore,	permit. Pages 1 and 2 Department of Health Important: If Item 27 any injury or other tr: once.		20a. Met/lod of Disposition 1	Removal from State	ce of Disposition (Name of Disposition (Name of Disposition) or other place of the	dens 3/16	109 20c.	Bel Air	vn, State
Balt	permit. Departimont any inj		21. Signature of Funeral Service Licent	Kmarks	22. Name and Address	ss of Facility Evan	is Fluner Forest t	al chair	el-Belmr 21050
	Physician /Medical		23a. Part 1. Enter the disease, or compands, or heart failure. List only of the compand of the compa	a. Due to (or as a consequer	spiratory	g, such as cardiac or re Lailu	espiratory arrest,	,	Approximate Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Selosis Due to (or as a consequer	nce of:	é			
	ate be executed lysician and he burial-transit	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Encenn Due to (or as a consequer d. Multi O	ato parne	lifure			
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of dea 9 □ Unknown	eath 3 Ectopic pregnancy	/		23d. Date of delive Month	ry Day Year
rds, P.	luires that t n signed by ild be detad	d by Ph	Part II. Other significant conditions of	ontributing to death put not resulting	ng in the underlying cause give	en in Part I.		use contribute to th	e cause of death?
Division of Vital Records,	The law req ate has bee bage 2 shou	Completed by	Ambulatory	dysfunct	ìon		24a. Was an autopsy performed? 1 □ Yes 2 🔊	prior to cor	osy findings available npletion of cause of
/ital	cian: ertifica ector, p	Be C	25. Was case referred to medical examiner?	H	I au	26. Place of Death (C	_	10 10 10 10 10 10 10 10 10 10 10 10 10 1	2 2 1 1 0
on of \	ding Physi h. After this c funeral dire		1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	R/Outpatient 3 DOA Other 8b. Time of Injury M 1 1	4 Industrig Home	5 ☐ Residence d. Describe how inj	6 ☐ Other (Specify occurred)
Divisi	al or Atten s after deat I Director: d in by the	Certification: To	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined				Location (Street of City or Town, Sta	and Number or Rura ite)	Route Number,
	ne Hospit. n 24 hours ne Funera pletely fille	Medical C		ysician: To the best of my knowledger. On the basis of examination and manner stated.					
	To the To the Comp	M	29b. Signature and title of certifier	Juy. M	10 29c. Licenso	e number 05950)	29d. E	Date signed (Month, 1	Jay, Year)
	2		30 Name and address of person who		3a) (Type, Print)	no 2198	21		

State Registrar

31. Date filed (Month, Day, Year) MAR 17 2009 BOWST.

32 Progressive Signature

Divers B. fault

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#28c-e-f, perPHYS G889 3/17/09 WS State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Heavrin **Physician** 2000 March /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** n/a The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 MD 78 March 18, 218-26-5397 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 1 Yes 2 No Director Cockeysville MD Baltimore 10f. Zip-Code 10g, Citizen of What Country? 10e. Street and Number 21030 USA 2 Hillary Way Funeral . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. em 27 is marked other than "natural", or itee 1 ☐ Yes 2 ☐
If Yes, Give
Year or Dates: 1 Never Married 2 Married 2 **X**No 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: white Ş Q 3 Widowed 4 Divorced er than "natural", the Medical Exa Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Office Manager Mechanical Contracting 12 n/a 18. Mother's Name (First, Middle, Maiden Surname, injury or other traumatic event, 17. Father's Name (First, Middle, Last) Be Mary Claire Lee Daniel Edward Lauterbach, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) William H. Heavrin/husband Department of Health a Important: If item 27 is any injury or other trac once, 2 Hillary Way, Cockeysville, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Dulaney Valley Memorial Gardens 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Timonium, MD 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley 10 W. Padonia Rd., Timonium, MD 21093 21. Signature of Fundre Inc. Michael Approximate Interval Between Onset and Death that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or one cause on each line shock, or heart failure. List only Immediate Cause (Final Intraparench 3 days **Physician** disease or condition resulting in death) /Medical Due to (or Examiner day if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) 3 - Ectopic pregnancy
5 - Other (specify) CERTIFICATION APPROVED BY SECURAL EXAMINES Division of Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death Month Day Year Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ate has b performed' 2 No 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: Hospital: 1/ Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Yes 2 ☐ No ၉ After this 28d. Describe how injury occurred Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Injury 1
Natural 5 Pending investigation Patient tel 1 X Yes JIJKNOWN 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 2 Accident Director: A 6 Could not be determined 3 Suicide 28f. Location (Street a Number of Rural Rough Number, City or Town, Stat. 1511 Serpentine Rd. 4 - Homicide Office Building

Macking Continuing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the dause(s) and manual m MD 21209 within 24 hours a

To the Funeral C

completely filled filled 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number K.es -10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Gartinke 32. Registrar's Signature

DHMH 17 Rev 1/200

State Registrar

31. Date filed (Month, Day, Year)

#AR 1 7 2009

ORIGINAL.

Everton Haughton,	1- For State Certificate of	Health and Mental Hygie	
Physician/ Medical Examiner	Registrar 1. Decedent's Name (First, Middle,Last) Everton Anthony Haughton, Jr.		Nate of Death North Day Year Parch 11, 2009 3. Time of Death 1723 hrs
	4a. Facility Name (if not institution, give street and number) Johns Hopkins Hospital		4c. County of Death N/A
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 218-27-6782 1 XM 2 F 19 Yrs.	Months Days Hours Min.	Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
· · · · · · · · · · · · · · · · · · ·	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locati		Ian. 8, 1990 Marryland 10d. Inside City Limits
Aaryland 28a-f show I at once.	Maryland N/A Baltim	Ore 10f. Zip Code	1 X Yes 2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once-tuneral Director	130 N. Collington Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13. War	21231 Decedent of Hispanic Origin? (Specify	USA y Yes or No- 14. Race - American Indian, Black,
5 TO T	1 XNever Married 2 Married Armed Forces? 1 Yes 2X No 3 Widowed 4 Divorced If Yes, Give Year	es, specify Cuban, Mexican, Puerto Rica Yes 2 ^X No <i>specify:</i>	
2 hours "natur	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	's Usual Occupation (Give kind of work sst of working life. DO NOT use retired)	
0036 within giene. Iter tha	11th grade Nev	er employed 18.Mother's Name (Fin	st, Middle, Maiden Surname)
Baltimore, MD 21215- pernit, Pages I and 2 should be filed Department of Health and Montal Hy Important: If item 27 is marked of injury or other transmatic eyent, the	Everton A. Haughton, Sr. 19a. Informant's Name/Relationship (Type, Print) Carand Grand Grand Grand 19b. Mailing	Address (Street and Number or Rural	Fowling Route Number, Lity or Town, State, Zip Code) 21231
re, MC s I and 2 sl f Heatth an If item 27 er trauma	Demetrius G. Whitted/Father 130 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State crematory or often	tion (Name of cemetery, Da	Avenue Baltimore, Md 20c. Location - City or Town, State
altimo mit. Page partment o portant: I	4 Donation 5 Other Specify: Woodlawn	Cemetery 3/21 ame and Address of Facility Chat	/09 Woodlawn, Maryland man-Harris FuneralHome
Physician	23a Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Acute Airway Obst Immediate Cause (Final disease a Injuries With Trach	40 Reisterstown	Pd Paltimore Md 21215
/Medical	Immediate Cause (Final disease or condition resulting in death) a. Injuries With Trach Due to (or as a consequence of):	eostomy	Death
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		
e executed ian and ial - transit			
50, te be exe sysician a burial -	X UNPENDED AMENDED 23a,27,28a-f I	per me g890 4-20-09	9 vt
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be execution that A hours after death. The law requires that the death certificate be execution the Funeral Director. After this certificate has been signed by the attending physician an appliety filled in by the funeral director, page 2 should be detached for use as the burial - in director. To Be Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1	tal death 3 Ectopic pregnancy ner (Specify)	Month Day Year
P.O. Bc that the des sned by the z detached fo		inderlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown
Division of Vital Records, P.O. rate or Attending Physician: The law requires that the an Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach artification: To Be Completed by P.		2	24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of
II Recominist The language 2 tor, page 2		26.Place of Death (Check only	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No 7 one)
ion of Vital etending Physician: cor: After this certif the funeral director,	1 V Yes 2 No Inpatient 2 V EN/Outpatient 2 V EN/		ome 5 Residence 6 Other: d. Describe how injury occurred subject burn
Division o Division of Attending parts of Attending neral Director: Aft filled in by the fune Certification:	1 Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, stre	·	imself while having seizures f. Location (Street and Number or Rural Route Number, City
Divisior Divisior Divisior Division of Attend Paneral Director: rely filled in by the in a Certification		1	or Town, State)
To the Host within 24 ho To the Funitor Completely 1 Medical Completely 1	(Check only one) 2 ✓ Medical Examiner: On the basis of examination and/or investigation and manner stated. 29b. Signature and title of certifier	ition, in my opinion, death occurred at the 29c. License number	e time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
	aueD_	O.C.M.E.	March 12, 2009
0	20 Decided Constant	Street, Baltimore, MD 21201	
State Registra	** * * * * * * * * * * * * * * * * * *	arkel	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #1,perMD, 9889 3/27/09 TT

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	otato of Marylan		tificate of			g. No. 2009	08255
	Physici		1. Decedent's Name (First, Middle, Last Edward T. Huro	Edwin liligh	man Hu	rd1e		2. Date of Death Month March 1	Day 2009	3. Time of Death 5:58A M
- J	/Medio Examin		4a. Facility Name (If not institution, give Stella Maris			4b. City, Town, o	r Location of Death		4c. County of Death Baltimo	.1
	Funeral Director		5. Social Security Number 6. S 215-01-6821	ex 7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay, OCT 15,	Year) 9. Birth Cou , 1917 Mar	place <i>(State or Foreign ntry)</i> yland
	e Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Baltimo		, Town or Loc Esse					10d. Inside City Limits 1
	th with the 23a or 28	al Director	10e. Street and Number 510 N. Stuart	Street		10f. Zip Code 21 2	21	10	g. Citizen of What Cour	ntry?
980	should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, I'm Model Evan, i'm I nist by mulling at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 12 Yes 2 ☐ No If Yes, Give Year or Dates:		Vas Decedent of H fYes, specify Cuba □Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	etc.
Baltimore, Maryland 21215-0036	d within 72 he giene. er than "natui	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 1 2	ducation ide completed) College (1-4or 5+)	(Give I life. D	ent's Usual Occup kind of work done o OO NOT use retired stal Clo	during most of worki d)	ing 10	6b. Kind of Business/In	•
and	thould be filed nd Mental Hygi marked other matic event,	To Be C	17. Father's Name (First, Middle, Last) Earl J. Hurd				18. Mother's Name	(First, Middle, Ma	,	
Mary	C 12		19a. Informant's Name/Relationship (7	,	19b. Mailin 1874	g Address <i>(Street</i> Tank Ro	and Number or Run		City or Town, State, Zip LNKSburg	Code) 21048
imore,			20a. Method of Disposition 11 Burial /2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State Care	ace of Dispos emetery, crem dens (sition (Name of natory or other place DI Fait	n 03/1		Oc. Location - City or To Baltimore	
Balt	permit. Page Department Important: If any injury or once.		21. Si mature Funeral Sérvice Local	see WWW	22. Co	Name and Addres	ss of Facility 300 Funeral	Mace A Home c	Ave. Balt: of Essex	imore MD 21221
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that caused the death one cause on each line. PANCREATIC CA Due to (or as a consequ	ANCER	er the mode of dyin	ng, such as cardiac o	or respiratory arres	st,	Approximate Interval Between Onset and Death
	certificate be executed reding physician and ise as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	,					
n '	attending for use a	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnal 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 🗌	Ectopic pregnancy Other (specify)	у		23d. Date of delive	ery Day Year
rds, P	quires that in signed build be deta	by P	Part II. Other significant conditions co	ontributing to death but not resu	Iting in the un	derlying cause give	en in Part I.		cco use contribute to the	
al Record	Io the hospital or Attending Physician: The law requires that the of within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Completed			-			24a. Was an autopsy performe	prior to cor	psy findings available mpletion of cause of
or Vital	nysiciar this certif al directol	To Be	To les ZAINO	Hospital: 1 ☐ Inpatient 2 ☐ E			4 🗀 Nursing Hor		ce 6 X Other (Specifi	y) HOSPICE
VISION	dtending F death. ctor: After y the funera	Certification:	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day, Year)	28b. Time of Injury		Yes 2□No	28d. Describe how	injury occurred et and Number or Rura	I Pouto Number
<u>.</u>	pital or yours after eral Dire		4 ☐ Homicide determined	building, etc. (Specify,)			City or Town,	State)	
	thin 24 he the the the the the the the the the	Medical	(Check only 2 Medical Examone X Nurse Pract	niner: On the basis of examinati	ion and/or inv	estigation, in my o	pinion, death occurr	ed at the time, date	e and place, and due to	the cause(s)
	¥ 2 8		30. Name and address of person who co	Seampleted course of death (1)	22a) /Tim - 17	29c. License	4792	290	3/11/2009	Jay, Teal)
			JACKIE JONES, CRN	P 2300 DULANE	Y VALL	,	TIMONIUM,	MD 21093	3	
	Stat Registra	e	31. Date filed (Month, Day, Year) RAR 1 7 2009	32, Registrar's Signatu	Janes					

DHMH 17 Rev 1/2001

5:58 а.ш.

MARCH 11, 2009

EDWIN HURDLE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March **Physician** 14, 2009 CANNEN HAMMOND 10:04 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 24 Hrs. 8. Date of Birth
Hours Min. DEC. 1, 1952 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 □ м аДУГ 217-62-6855 56 Marvirand Director Usual Residence of Decedent 10h County 10c, City, Town or Location 10d. Inside City Limits 10a. State 28a-f show Department of Health and Mental Hygiene.
Important; if Item 27 is marked other than "natural", or items 23a or 28a-f shou any injury or other traumatic event, the Mydical Examinar must be notified as 1 □ Yes 2 🕅 🐪 Vo Director Baltimore Timonium Marvland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21093 USA 12107 Tullamore Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 □ Yes 2 X No Specify. Specify. \$ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Personal Assistant Balto Co Board of Ed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Charles Willis Hammond Sr Sue Hendry ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) C Willis Hammond Sr Father 615 Chestnut Avenue Towson Maryland 21204 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 XX remation 3 ☐ Removal from State GreenMount Crematory Mar. 16,2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fa例外tchell-Wiedefeld Funeral Home Inc ignature of Funeral Service Licenses 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final S'e pSis Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or / a consequence of) certificate be executed Exami burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the burial Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signage 2 should b Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No performed' certificate malnu 1 Tyes Hospital or Attending Physician: '44 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 231 No 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral D 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year tenderson 195 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NA 10 oad If Under 24 Hrs. 9. Birthplace (State or Foreign Gountry) If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 1 № M 2 🗆 F 578-76-4881 6-24-53 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Mes 2 □ No Itimore MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Koad 212.06 arien Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disable 2+h Grade NA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Henderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) Daughter landa 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ignati of Funeral Service Licensee Joseph 23 . art1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of heart failure. List only one cause on each line.

Imprediate Cause (Final dease or condition a. In the cause of condition a. Approximate Interval Between Onset and Death IVER month esulting in death) Due to (or as a consequence of) metastat if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 3d. Date of delivery Month Day Year se contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Department of Health ar Important: If item 27 is any Injury or other trau

Physician

/Medical

Examiner

Funeral Director

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Be Completed

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Examiner

Physician/Medical

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Completed

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Certification: To

Medical

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, I'm Medical Evaninal must be notified at

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed sician and burial-tran physician a the attending p signed by the peen has le 2 s page 2 After this certificate funeral director, page or Attending Physician:

P.O. Box 68760,

Division of Vital Records,

death.

hours after within 24 hours a the Hospital

neral Director: A

3b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic preg 5 ☐ Other (special		2
art II. Other significant conditions	s contributing to death but not resulting in t	he underlying caus	e given in Part I.	23e. Did tobacco us 1 ☐ Yes 2
				24a. Was an autopsy performed 1 Yes 242 No
5. Was case referred to medical	14.	0	26. Place of Dea	ath (Check only one)
examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	oatient 3 DOA	Other: 4 Nursing H	lome 5 Residence 6
7. Manner of Death	28a. Date of Injury 28b. Ti	me of 28c.	Injury at Work?	28d. Describe how injury

☐ Other (Specify) occurred 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

AJ414735

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Broadway Baltimore MD HIGHINS, 31. Date filed (Month, Day, Year)

State Registrar

		1	For State Registrer	State of Ma	aryland	d / Depa <i>Cer</i>	rtment <i>tificate</i>	of H	ealth a D <i>eath</i>	and Me		gienę Reg. No		8 0 8	258
	Dhysiair		1. Decedent's Name (First, Middle, L	•	-						2. Date of De. Month	ath Da	y Ye		of Death
	Physicia /Medic	al -	Myong Sun	Hwang						15 1	March	15,	2009	4:1	<u>ам</u>
ě.	Examin	er	4a. Facility Name (If not institution, g				4b. City, T			of Death			. County of D		
			Randolph Hills 1 5. Social Security Number 6.			ast birthday)	Rocl	1 Year	If Under	24 Hrs.	8. Date of Bir (Month, Da		Montgo 9.	Birthplace (Stat	e or Foreign
1	Funeral Director		212-96-5012	·	30	Yrs.	Months	Days	Hours	Min.	7/7/19:	y, Yea <i>r)</i> 28		Country) NOT KOT	th
	P .		Usual Residence of Decedent 10a. State 10b. County		100 City	. Town or Lo	oation								City Limits
	show	ž	MD Montgom	orv	Too. Ony	Rockv									es 2 No
	the N	Director	10e. Street and Number	CLY		1100111	10f. Zip (Code				10g. Ci	tizen of Wha	t Country?	
	3e or	0	10765 Gloxinia	Drive				2085	52				USA		
	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		S. 13.	Vas Decede	ent of Hi	spanic Or	igin? (Spe	cify Yes or No Rican, etc.)	-		American Indian Vhite, etc.	
ထ္	after or Ite		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 X I If Yes, Give			1 ☐ Yes 2	_	Specify				Specify:	Asian	
8	filed within 72 hours after death with the Maryland Hygiene. Hygiene. so the Hygiene then "natural," or Items 23e or 28e-f show ent, the Medical Executar Investical Executarians.	d by	3 ₩idowed 4 □ Divorced 15. Decedent's	Year or Dates:	1		dent's Usual		ation			16b K	(ind of Busine		
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b	al Hyg	Be Completed	17. Father's Name (First, Middle, La	st)			_		18. M oth	er's Name	(First, Middle,	Maider	Sumame)		
yla	Ment Ment Markec	2				uknow		(2)			(D) (M) (1)	0'+-			nown
Mar	12 sh h and 7 Is m treum		19a. Informant's Name/Relationship Chae Kim / Dai	ughter		1	_				Route Number			re, 2/p Code)	
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altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or items 23e or 28e-f show eny injury or other treumatic event, the Madical Ever-treumst by Inclined at Once.	1	21. Signature of Funeral Service Lic	enspenorota M		all 22	Name and	d Addres	s of Facil	ation	Servi	ces			
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			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused ly one cause on each li	d the death ine.	n. Do not ent	er the mode	e of dyin	g, such as	s cardiac o	r respiratory a	rrest,		Approxir Interval Onset a	nate Between nd Death
į	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Chro	onic	Obstru	ctive	Pul	mona	ry Di	sease				
	/Medical Examiner		resulting in deathy	Due to (or as	a consequ	uence of):									
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0	a exectant and and arrial-to		resulting in death) Last	Due to (or as	a consequ	uence of):									
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9 x	eath certific attending p for use as f	/Me	IF FEMALE:	23c. If yes, outcome	of pregna	incv							23d. Date of	f delivery	
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Ö		hysi	9 Unknown	9□ Unknown											-
S,	law requires that the de as been signed by the a 2 should be detached f	by P	Part II. Other significant condition	-	out not resi	ulting in the u	nderlying ca	ause giv	en in Part	I.				te to the cause	
ord	w require been signal		Parkinson's D	isease			-				10	Yes 2	!∐No 3[Probably 4	Zuknown —
Vital Records,	e lawr has be	Completed									24a. Was	psy	24b. Wer prior deat	e autopsy findir r to completion	gs available of cause of
E	The ate pag	Con									1 ☐ Yes	2 XN		Yes 2□ No	
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o		To To	1 ☐ Yes ② No 27. Manner of Death	28a. Date of Inju		ER/Outpatie		8c. Injur Wor	44(3) 11		ne 5 Resi 28d. Describe			Specity)	
ion	Attending Ph r death. ector: After th by the funeral	ation	1 Matural 5 ☐ Pending 2 ☐ Accident investiga		ay Year)	Injury	М		k? Yes 2□]No					
Division	or Attendated or after deatl	ertification;	3 Suicide 6 Could no 4 Homicide determin		jury - At ho	ome, farm, st	reet, factory	, office		:	28f. Location (City or To			or Rural Route N	lumber,
Ö	To the Hospitel or Atter within 24 hours after de To the Funerel Directo completely filled in by th	O													
	Hosp 14 hou Fune fely fil	edical		Physician: To the best caminer: On the basis of and manner s	of examina										60(s)
	ithin 2 o the	Mec	29b. Signature and title of certifier	A A	lateu.		290	. Licens	e number	,		29d. D	ate signed (A	Month, Day, Yea	r)
	- 5 - ŏ		1		ml	//	1	D52	2261			3	3/15/20	009	
•	\		30. Name and address of person w	no completed cause of	death (Iten	п 23а) (Туре	Print)								
	\		Alan R. Segal M.				kville	e, M	D						
	St Regist	ate rar	31. Date filed (Month, Day, Year)		rar's Signa	A A	a del								

Physicia	ar
/Medic	a
Examin	eı

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinating the notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

> State Registrar

	For State of Ma	aryland / Dep <i>Ce</i>	artment of F ertificate of I		nental Hy	/gien Reg. No		08259
	1. Decedent's Name (First, Middle, Last)				2. Date of De	eath Da	ay Year	3. Time of Death
an al	HARRY, O. HUF	F			March		5 2009	01:30PM
er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		40	. County of Deatl	n
	MERCY MEDICAL CENTER		BALTIN	•			NIA	
	3/7VM 0 🗆 🗆	e (In yrs. last birthday)	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	av. Year) Co	nplace (State or Foreign untry)
	224-12-0027	90 Yrs.			Feb. 3	, 19	19 Wash	ington DC
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation					10d. Inside City Limits
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ect						100.0	itizan of Mihat Ca	
큡	10e. Street and Number		10f. Zip Code	24 2 2 2			itizen of What Co	unitry?
eral	600 Light Street Unit 628	5		21230			USA	dana la dina
Š	11. Marital Status 12. Was Decedent to Armed Forces? 1 Never Married 2 Married 2 Married	Ever in U.S.	Was Decedent of H If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	0-	 Race - Amer Black, White 	
by F	1 Never Married 2 Married 1/2 Yes 2 1/2 If Yes, Give Year or Dates:	WWII	1 □Yes No	Specify:			Specify: Wh	ite
Be Completed by Funeral Director	15. Decedent's Education		edent's Usual Occup	ation		16b. h	Kind of Business/I	ndustry
plet	(Specify only highest grade completed)	(Give	e kind of work done of DO NOT use retired	during most of work	ing		eating a	
mo	Elementary/Secondary (0-12) College (1-4or 5	1+)	Mechanic				r Condit	
C	17. Father's Name (First, Middle, Last)	<u> </u>		18. Mother's Name	e (First, Middle	, Maide	n Surname)	
To B	William D. Huff			Henriett	a			
_	19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ing Address (Street	and Number or Rui	al Route Numl	ber, City	or Town, State, Z	ip Code)
	William Huff Son	10	E. Lee S	treet Uni	t 1503	, Ba	ltimore.	MD 21202
	20a. Method of Disposition		osition (Name of matory or other place		Date		ocation - City or	
	1 ☐ Burial	Atlantic	Cremator	ÿ 3/17/	2009	Gle	n Burnie	, MD
	21. Signature of Juneral Service Licensee) p	2. Name and Addre	ss of Facility		1		•
	Num B. Hen	3	urgee-Hen 631 Falls	Road, Ba	runera Itimore	L HO ∋, M	me, Inc. arvland	21211
	23a. Part 1. Enter/ine disease, or complications that caused shock, or heart failure. List only one cause on each lir	the death. Do not en						Approximate Interval Between
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am	Cause (Disease or injury that initiated events c.							
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an/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome	2 Fetal death 3	☐ Ectopic pregnanc	y			23d. Date of deli Month	very Day Year
sici	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant a 9 ☐ Unknown	t time of death 5	Other (specify)				WOUTH	Day Teal
Be Completed by Physician/M	Part II. Other significant conditions contributing to death b	ut not reculting in the	Inderlying cause chi	an in Port I	230 Did	tobacco	use contribute to	the cause of death?
by	Tartin Guler significant conductors contributing to death b	at not resulting in the t	andenying cause giv	anniranti.		Yes 2		obably 4 Unknown
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nple					24a. Was	psy	prior to c	topsy findings available completion of cause of
Co					pen 1 □ Yes	ormed? 2 ☑N	death? o 1 ☐ Yes	2 □No
	25. Was case referred to medical examiner?		Tous	26. Place of Deat	h (Check only	one)		
2		ent 2 ER/Outpatie		4 LI Nursing Ho			6 ☐ Other (Spec	cify)
ion	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Da	y, Year) 28b. Time of Injury	Worl		28d. Describe	now inju	iry occurred	
cat	2 Accident investigation 3 Suicide 6 Could not be	441		Yes 2□No	001 11'	(2)		
irtif	4 Homicide determined building, etc.	ury - At home, farm, st c. <i>(Specify)</i>	reet, lactory, office		City or To	wn, Stat	na Number or Hu 'e)	ral Route Number,
ŭ	29a. Certifier 1 Certifying Physician: To the best	of my knowledge, dog	th occurred at the #	ne date and place	and due to the	2 Callee/	s) and manner on	stated
Medical Certification: To	(Check only one) 2 Medical Examiner: On the basis of and manner str	f examination and/or i	nvestigation, in my o	pinion, death occur	red at the time	, date ar	nd place, and due	to the cause(s)
Me	29b. Signature and the of certifier		29c. Licens	e number		29d. D:	ate signed (Month	n, Day, Year)
	MD MD		277	986		ma	RCH, 15	2009
	30. Name and address of person who completed cause of d	eath (Item 23a) (Type		100		11/1	ML 17, 15	12001
		L CENTER,		ZALLI DI DI	F. BAIS	Tima	PE MO	21202
te	31. Date filed (Month Day, Year) 32. Registra	ar's Signature		inc PUII	V (VII)	117/0	TILLY	
ar	MAK 1 7 2009 Serger	ar's Signature	No.					

			For State Registrar	State o	t Mar	yland / Depa <i>Cer</i>	irtment of H <i>tificate of L</i>			lene.	2009	08260
	Physicia	an	1. Decedent's Name (First, Midd						2. Date of Dea Month	Day	Year	3. Time of Death 3:40 AM
~	/Medic Examin	al	MILGIEG 4a. Facility Name (If not institution	C. Hoffman				Location of Death	MAK	14 4c.	2009 County of Death	2/70/11
- 1			ST AGNES	MOSITA		" this is the standard	SALT//		O Date of Birth		O Disthe	Non (State or Foreign
	Funeral Director		5. Social Security Number 214–18–3699	6. Sex 1 □ M 2 □ □ F	-	(In yrs. last birthday) 92 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 06-11-	Year) 1916	Ohio	place (State or Foreign htry)
	/land		Usual Residence of Decedent 10a. State 10b. County	,	1	0c. City, Town or Lo	cation				1	0d. Inside City Limits
	e Man Ba-f sh	ctor	MD Bal	timore			Catons	ville				1 ☐ Yes 2 HNo
	with th	Dire	10e. Street and Number 2 Bristol Hill	Court, A	ot.]	B4	10f. Zip Code 21	228		10g. Citiz	zen of What Cour United	
(0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar mant be rediffied at once.	Funeral Director	11. Marital Status 1 □ Never Married 2 □ Mar	12. Was Dece Armed Fo	edent Evorces?	er in U.S. 13. \		ispanic Origin? (Sp un, Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Americ Black, White,	
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land	id be fil ental H ked otl ic even	To Be	17. Father's Name (First, Middle Harold Carle	, Last)					e Howel:		Surriame)	
ary	shoul and M is mar	F	19a. Informant's Name/Relation				•	and Number or Rur		-		
e, E	1 and 2 Health em 27 Ither tr		Jean Hoffman - 20a. Method of Disposition	daughter		20b. Place of Dispo		11 Rd., B	altimore		aryland	
mor	Pages nent of int: If it		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3	3 ☐ Removal from Specify)	State	Meadowric			7-09	E1kr	idge, Ma	ryland
Baltimore, Maryland 21215-0036	permit. Departr Importa any Inju		21. Signature of Funeral Service	Liensee M(0005			^{ss of Facility} Gar , 7250 Wa				1 Home at MD 21075
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1	Physician /Medical		immediate Cause (Final disease or condition resulting in death)	_aA		consequence f):	erdial	Infa	ection			2 degs
ľ	Examiner		Sequentially list conditions	b.	(OI as a	consequence my.						
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928	cate be physici the bu	edical		d								
P.O. Box 6	aath certi attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown		birth 2 nant at t	☐ Fetal death 3 ☐	Ectopic pregnanc Other (specify)	у		2	23d. Date of deliv Month	ery Day Year
	law requires that the das been signed by the 2 should be detached	δ	Part II. Other significant condit	ions contributing to d	leath but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to			he cause of death?
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/ital	cian: T ertificat ector, pa	Be C	25. Was case referred to medical examiner?					26. Place of Deat		· · · · · ·	1 Tes	2 🗆 140
of/	Physic r this c	၉	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 🔀		t 2 ER/Outpatier		4 LI Nursing Ho	ome 5 Resid		Other (Speci	<u>(y)</u>
ion	ath. ath. rr: Afte	ation	1 Natural 5 ☐ Pendi 2 ☐ Accident invest	tigation	nth, Day,	Year) Injury	Worl				•	
Divis	al or Atten s after deat Director: d in by the	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 286. Flace	e of Injury ling, etc.	y - At home, farm, str (<i>Sp</i> ec <i>ify</i>)	eet, factory, office		28f. Location (S City or Tow		d Number or Run)	al Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director; After this certificate he completely filled in by the funeral director, page	dical	(Check only 2 Medica one)		basis of e	examination and/or in ed.	vestigation, in my	opinion, death occur	rred at the time,	date and	place, and due t	o the cause(s)
	To the To the company	Me	29b. Signature and title of certifi	awry .			29c. Licens	6 2 5 6		29d. Dat	e signed (Month,	Day, Year) 79
	10		30. Name and address of person 13/C4 DV3 N	who completed cau	se of dea	ath (Item 23a) (Type, Majzley	Print) hora	LN , (Balti	nor	e MS	21228
	Sta Registi	ite rar	30. Name and address of person (MAR 17)	2009 Sen	Registrar	's Signature	Kel					
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DHMH 17 Rev 1/2001

MILBRED HOFFMAN

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Year **Physician** JOHN HAROLD 03 2009 7.08 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HANOVER ANNE HRUNDEL ROAD LEEDS If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours Director 217-46-3761 62 08-12-1946 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 23s or 28a-f show florportant: If item 27 is marked ofher than "natural", or items 23s or 28a-f show any injury or other traumatic event, "the "Medical Examine could be notified at 1 ☐ Yes 2 ANo Director MD Anne Arundel Hanover 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7 Leeds Road 21076 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates Specify à 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plumber Plumbing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Henry Harold, Jr. Margaret Virginia Woodard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Jean Harold - wife 7 Leeds Rd., Hanover, Maryland 21076 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Md Veterans Cem. 03-16-09 Crownsville, MD 4 Donation 5 Dother (Specify) M00053 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature of Funeral Service Licensee Marle M. MMP., Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** FAILURE HEPATIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CELL CARCINOMA OF LIN SMALL METASTATIC Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-trar Due to (or as a consequence of): the attending physician thed for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. ed by the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ASCITES 1 ☐ Yes 2 ☐ No 3 ☐ Probably MALIGINANT 4 Unknown Completed director, page 2 should certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 □No 1 □Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, F. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 □Yes 2 □No 2 Accident 6 □ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0057-936 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 225. Crenest. Baitmure mo 21201. Heather & Mennuel Mo 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 08262

		1- For State Registrar		Certi	ficate of	Death			Reg. No.			
Physicia	an/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death North Pay Year											
ledical Exami	ner	Deborah Ann						March 1	2, 2009	0407 hrs		
		4a. Facility Name (if not institution 1151 Defense Highwa	-	umber)	41	o. City, Town, or L Gambrills	ocation of De	eath	4c. County of Anne Aru	Death Indel		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last	t birthday)	If Under 1 Year			Birth (MM/DD/YYYY)	Birthplace (State or Foreign Country)		
Director		220-76-9643	1 M 2 F	47	Yrs.	Months Days	Hours	Sept.	29,1961	Maryland		
any		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Locatio	n			 	10d. Inside City Limits		
Aaryland 28a-f show 1 at once.	for		Arundel	Co. Gam	brills	101 7 0 1			10g. Citizen of Wha	1 Yes 2 X No		
th the Mary 23a or 28a notified at	Director	10e. Street and Number 1151 Defense	Highway			10f. Zip Code 210!	54		United	·		
h with t ms 23a be not	Funeral	11. Marital Status	12. Was De	cedent Ever in U.S.			anic Origin?	(Specify Yes or erto Rican, etc.)		American Indian, Black,		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once		Never Married 2 X M Widowed 4 Div	1 Yes	2 X No		Yes 2X No		,		White		
hours afte 'uatural'', Examiner	d by	15. Decedent's Education (Spe	or Dates:		6a. Decedent	s Usual Occupation	on (Give kind		16b. Kind of Bus			
16 n 72 he nan "n ical Es	Complete	Elementary/Secondary (0-12)	College (1-4 or 5+)		st of working life.			A111	S Danie Harant		
5-0036 led within 7 Hygiene. other than	omo	17. Father's Name (First, Middle	Last)		Counse	elor / Se			e, Maiden Surname)	& Drug Treatmt		
215 215 be filed mtal Hy rked of	Be C		aro				Mild	•	Sadler			
nore, MD 21215-0036 ges I and 2 should be filed within 72 nt of Health and Mental Hygiene. nt: If item 27 is marked other than other fraumatic event, the Medical	ပ	19a. Informant's Name/Relations		'ha.h.a.m. d					lumber, City or Town			
, MD and 2 sho ealth and een 27 is fraumati		Mr. William F.	naygne /			Defense		ay Gam	brills, M	D 21054 City or Town, State		
Baltimore, Mpemit. Pages I and 2 Department of Health Important: If item 2		1 X Burial 2 Cremation		TOTH State	ematory or other		ark 3	/19/2009	Glen Bu	rnie, Maryland		
Baltin permit. P Departme Importan injury or		4 Donation 5 Other S 21. Signature of Superal Service		1010.						& Cremation		
		Marc.C.	11/	M01121	Ser	vices PA	A: 1 2:	nd Ave S	W. Glen B	urnie, MD 21061		
Physician /Medical		23a. Part I. Enter the disease, of failure. List only one cause	on each line.				such as cardi	ac or respiratory	arrest, shock, or nea	rt Approximate Interval Between Onset and Death		
xaminer		Immediate Cause (Final disease or condition resulting in death)		bronchop r a consequence of):		.a				564		
m - 1	L	Sequentially list conditions,	b									
	Examiner	if any, leading to immediate figure Filter Underlying Course (Disease or injury that initiated	C	a consequence of):								
and transit		events resulting in death) Last	4	a consequence of):								
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18760, tificate be ex ing physician as the burial	J/Me	IF FEMALE: 23b. Was decedent pregnant in t		outcome of pregna	ency 2 Feta	al death 3	Ectopic pre	egnancy	23d. Date of o	delivery Day Year		
P.O. Box 68 s that the death certi gued by the attendin edetached for use as	icia	past 12 months?	4 Preg	nant at time of deat	<u> </u>	er (Specify)			Moritan	Day Toda		
Box the death cy the attenty the attention	Physicia	Yes 2 No 9 ✔ Un Part II. Other significant condit	9 Oliki		ulting in the u	derlying cause o	ven in Part I	23e. Di	d tobacco use contrib	oute to the cause of death?		
, P.O ires that to signed by I be detac		Tart II. Other significant condi-	contributing	to ceatir but not res	diting in the di	idenying cadse g	ven in i arri.			Probably 4 Unknown		
of Vital Records, ng Physician: The law require After this certificate has been signered in rector, page 2 should b	Completed by	·						24a. W		Vere autopsy findings available rior to completion of cause of		
of Vital Recoing Physician: The law After this certificate has bineral director, page 2 s	omp							pe	rformed? de	eath? ✔ Yes 2 No		
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F Vit	To	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1		R/Outpatient			ursing Home 5	Residence 6 v			
ision of Vital Rec Attending Physician: The I r death ector: After this certificate I by the funeral director, page	ion:	1 X Natural	ding 26a, Date (Mont	e of Injury h, Day,Year)	28b. Time of In		y at Work? es 2 No		be now injury occurre	5U		
Division tal or Attendiu rs after death al Director: A	ficat	2 Accident Inve	stigation	ce of Injury - At hon	ne, farm, stree	t, factory, office bu	uilding, etc.			er or Rural Route Number, City		
Diversity of the pital of the p	Certification:	4 Homicide dete	rmined (Specify)				or Town	n, State)			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit.	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the be iminer: On the basis	est of my knowledge of examination and	e, death occu <mark>rr</mark> d/or investigati	ed at the time, da	te and place, death occur	and due to the cared at the time, da	ause(s) and manner ate and place, and du	as stated. ue to the cause(s)		
To To To Com	Med	29b. Signature and title of certific	and manner	stated.		29c. License				ed (Month, Day, Year)		
		hill le		MA		O.C.N	Л.Е.		March 12, 2	2009		
ϕ		30. Name and address of person	The state of the s			Done Chart	Daltim	MD 24204				
	ata	Russell Alexander MD 31. Date filed (Month, Day, Year)		Medical Exami		Penn Street,		, IVID 2 1201	· · · · · · ·			
5	તાલ	11. Date life (Month, Day, Year)	0 /	A	Barker	•						

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Registrar

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State Registrar 31. Date filed (Month, Day,

32. Registrar's Sanature

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 15,2009 **Physician** 10:22A M Dieter Kurt Jacob /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balto. 4229 Darleigh Rd. Nottingham 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 73 Yrs 213-44-3837 Director October 29,1935 Germany Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural"; or items 23a or 28a-f show traumatic event, Tre World Even, item to provide a 1 Yes 2 No Director Nottingham Md. Balto. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21236 4229 Darleigh Rd. Funeral death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married White Itimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Tool Works Co. Tool Maker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill ment of Health and Mental H lant: If item 27 Is marked oth Be Gerdrut Hollstein Kurt Jacob 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If Item 27 Is any injury or other trau Spouse Ann B. Jacob Nottingham ,Md,21236 4229 Darleigh Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore City, Md. Bayview 3-17-2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final STROKE **Physician** Mont disease or condition resulting in death) /Medical Due to (or as a consequence, of): Examiner Fibrullation MTRIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ending physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy o in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No After this certification Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 29a. Certifier DECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) within 2 To the and manner stated 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 059359 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BIVD SUME #200 Bohnose, MO 21236 ZOLLINGER 4924 RAYMOND 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 17 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene []

Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death Year **Physician** KAYE PATRICIA 1:45 PM MARCH 2009 /Medical 4b. City, Town, or Location of Death 4e. Fecility Name (If not institution, give street and number) 4c. County of Deeth Examiner Baltimore Cour ollege Manor If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Dete of Birth (Month, Day, Year) **Funeral** Days 1 □ M 21 ☑ F 73 219-32-4982 Yrs. Director September 9,1935 Maryland Usual Residence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic avant, the Medical Examiner must be notified at 1 ☐ Yes X☐ No Directo Balto. Nottingham Md. 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21236 USA 9636 Dundawan Rd. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 → Married 1 ☐ Yes 2√7 No If Yes, Give A Year or Dates: White 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Helen Schmitt Wallace Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 9636 Dundawan Rd. Nottingham, Md. 21236 Paul Kaye Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5□Other (Specify) Emtombment Lorraine Park Maus. 3-17-2009 Baltimore City, Md. 21. Signature of Funerel Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Multiple 20 years Examiner Physician/Medical Examiner attending physician and I for use as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) After this certificate has been signed by the a funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed by 24b. Were eutopsy findings evaileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 ☐ Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted Live 1 Yes 2 No Certification: To 28e. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 24 hours a Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To tha P within 2 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 TOWSON, MO 21284 Alexander MO Chen, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Hegistrar

DHMH 16 Rev 6/95

09-02066 Danny Kramer Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2009 08267

	Registrar	Certifica	te of Death	Reg.	No.		
Physician/ ledical Examine	1. Decedent's Name (First, Middle,La	• Kramer		2. Date of Death Month E March 13, 2	Date of Death Month Day Year 1130 h		
	4a. Facility Name (if not institution, gi 334 East 25th Street	ve street and number)	4b. City, Town, or Location of Baltimore	Death	4c. County of Dea	th .	
Funeral Director	5. Social Security Number 214-86-4778	7. Age (In yrs. last birtho	day) If Under 1 Year If Under Months Days Hours	24Hrs. 8. Date of Birth Aug. 26	1 6	irthplace (State or Foreign country) MD	
en de lectorate	Usual Residence of Decedent					,	
d Be.	10a. State 10b. County OH Madis	on Toc. City, Town of Wes	t Jefferson		10d. Inside City Limits 1 Yes 2 X No		
nylan nylan ti on ti	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Co	untry?	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Morital Hygiene. 27 is marked other than "naturial", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		Street	43162	T Y	USA		
or items 23 must be no	11. Marital Status 1 XNever Married 2 Marrie	d Armed Forces?	 Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, I 		14. Race - Ame White, etc.	erican Indian, Black,	
s after d	3 Widowed 4 Divorce	d If Yes, Give Yaar or Dates:	1 Yes 2X No specify:	nd of work done	Specify: W	hite	
hour hatu Exan	15. Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or 5+)	ecedent's Usual Occupation (Give ki rring most of working life. DO NOT u		ob. Nind of Busines:	s/industry	
5-0036 led within 72 he Hygiene tother than "ne the Medical Ex	12th	College (1-4 or 5+)	Self employed	1	Carpet		
Hygie othe		t)	18.Mother's	Name (First, Middle, Ma	iden Surname)		
2121 2121 Suld be fill Mental H marked ic event,		Kramer	Mailing Address (Street and Numb	atherine	Croed		
MD 21 12 should th and Me 127 is ma umatic ev		Type, Print) 19b. ricker /mother					
	20a. Method of Disposition		90 Jackson St		Jeilers 20c. Location - City		
5 2 E E E	1 Burial 2 XCremation 3 4 Donation 5 Other Specia	Removal from State Bayvi	y or other place) Ew Crematory	3/19/09	Baltimo		
Baltimo permit Page Department of Important: injury or ott	21. Signature of Funeral & rvice Lice		22. Name and Address of Facility	300 Mace	Ave. Ba	alto MD	
W F G E E	MULLEGA	110010	Connelly F	'uneral Ho	me of Es	sex 21221	
Physician	23a. Part I. Enter the disease, or con failure. List only one cause on	plications that caused the death. Do not each line	enter the mode of dying, such as ca	rdiac or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and	
Medical xaminer	Immediate Cause (Final disease or condition resulting in death)	Atherosclerotic Due to (or as a consequence of):	cardiovascular d	lisease		Death	
	Sequentially list conditions,)	- 5/4				
i di	if a ny leading to immediate cause. Enter Underlying Cause	Due to for as a consequence of:		,			
nted d ansit Fyamine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):					
18760, rrificate be executed ing physician and as the burial - transit	XUNPENDED	AMENDED 23a,PII,27,	perME, g890 4/23	3/09 TT			
18760, tificate be ing physici as the buri	IF FEMALE: 23b, Was decedent pregnant in the	23c. If yes, outcome of pregnancy	Fetal death 3 Ectopic	pregnancy	23d. Date of deliver	ery Day Year	
₩ = 2 %		4 Pregnant at time of death 5	Other (Specify)	pregnancy	Wionth	Day Teal	
the de ched f	Part II. Other significant condition	contributing to death but not resulting	in the underlying cause given in Par	t I. 23e. Did tob	acco use contribute	to the cause of death?	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the ras after death. "I Director: After this certificate has been signed by led in by the functal director, page 2 should be detach.	Cocaine abuse	0 0			2 No 3 P	robably 4 🗸 Unknown	
Records, The law require ficate has been sig page 2 should be				24a. Was ar autops		autopsy findings available o completion of cause of	
eco he law te has				perform	ned? death	?	
al Ra			26.Place of Death (
Vita	examiner?	Hospital: 1 Inpatient 2 ER/Ou	tpatient 3 DOA Other	Nursing Home 5 R	esidence 6 🗸 Ott	ner: Scene	
of Ving Physical Colored Color	27. Manner of Death	28a. Date of Injury (Month, Day, Year) 28b. T	ime of Injury 28c. Injury at Work?	28d. Describe ho	w injury occurred		
ion tendi teath.	Natural 5 Pending 2 Accident Investiga		1Yes 2	No			
Division ospital or Attending sours after death. neral Director: After filled in by the fune	3 Suicide 6 Could no determin	ot be 28e. Place of Injury - At home, far	m, street, factory, office building, etc	28f. Location (St or Town, Sta		Rural Route Number, City	
Spital hours interal y filled		(CD COLLY)					
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendi completely filled in by the funeral director, page 2 should be detached for use		cian: To the best of my knowledge, dealer: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place westigation, in my opinion, death occurred.	ce, and due to the cause curred at the time, date a	(s) and manner as sind place, and due to	the cause(s)	
F W T O	A	and manifer states.	29c. License number	T	29d. Date signed (A	Month, Day, Year)	
(0)	and.	FOR MARGARITA KOI	EELL O.C.M.E.		March 14, 2009	9	
		o completed cause of death (Item 23a)	111 Donn Street Baltiman	MD 21201			
		Assistant Medical Examiner 3. Registrar's Signature	111 Penn Street, Baltimore,	, IVID 2 1201			
	e 31. Date filed (Month, Day, Year)	Registrar's Signature	F				

			For State	State of M	laryland / Depa	artment <i>rtificate</i>			nd Me		001	0.0	001	2 6 0
			Registrar 1. Decedent's Name (First, Middle, La	st)		incarc	01 00	Catti		2. Date of Deat	eg. No.	17	3. Time of	Death
	Physicia /Medic		Ethel M.	Kiser					N	Month March	13 20	rear 09	03:38	
	Examin		4a. Facility Name (If not institution, gi)	4b. City, To					4c. County o			
			Genisis Elder Ca					a Par					undel	
	Funeral Director		,	Sex 7.A 1 □ M 2 🙀 F	ge (In yrs. last birthday) 80 Yrs.	If Under 1 Months		f Under 24 Hours	Min.	B. Date of Birth (Month, Day, March 2	Year) 4 1928	9. Birth; Coul	place (State o ntry) MD	r Foreign
			Usual Residence of Decedent					1		141011 2	1 1320			
	yland		10a. State 10b. County		10c. City, Town or Lo	cation						1	0d. Inside Cit	ty Limits
	Mar a-f st	ctor	Maryland Anne A	rundel			Ρā	asade	na				1 ☐ Yes	2⊠No
	th the	Director	10e. Street and Number			10f. Zip C	ode			1	0g. Citizen of Wi	at Cour	ntry?	
	ath wi	ra I	7735 Rockanna Ro	ad				2112				USA	4	
	tems	Funeral	11. Marital Status	12. Was Deceden Armed Forces		Was Decede If Yes, specif	nt of Hisp y Cuban,	anic Origi Mexican, I	in? (Spec Puerto R	ify Yes or No- ican, etc.)		- Americ White,	can Indian, etc.	
36	2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examinations to continue to the first of the following the first of the family of	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □Yes 2√2 If Yes, Give Year or Dates		1 □ Yes 2[JeNo S	Specify:			Specify:	W	hite	
9	tural		15. Decedent's E	ducation	16a. Dece	dent's Usual					16b. Kind of Bus	ness/In	dustry	
215	in 72 in "ne Media	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or	life.	kind of work DO NOT use	done duri retired)	ring most o	of working	7				
21	d with giene	E C	12		0.7	A	gent				Insur	ance	<u> </u>	
p	tal Hy d other	Be (17. Father's Name (First, Middle, Las				18				Maiden Surname)		
yla	Meni Meni arke	ဥ	Thomas C1	ator —————				Min	nie	Gra	ath			
Baltimore, Maryland 21215-0036	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship	(Type. Print)	19b. Mailii	ng Address (Street and	d Number	or Rural	Route Number	, City or Town, S	tate, Zip	Code)	
e,	1 and Health		J. Edward Kiser 20a. Method of Disposition	Jr. (son)	20b. Place of Dispo			ay, P	asad	ena, MI	21122 20c. Location - C	ity or To	uun State	
وّ	iges nt of h		1 ☐Burial 2 ☐ Cremation 3 ☐		cemetery cres	natory or oth	er place)	М	larch	17		•		3
華	it. Pa irtmei irtant injury		4 □ Donation 5 □ Other (Special Signature of Funeral Service Use	_		2. Name and		11	2009		Glen Bur			
Ba	permit. Pages 1 and 2 s Department of Health an Important: If Item 27 is a any Injury or other trau once.		21. Signature of ramera Service Co.	nsee					S		s Funer lena, MD			.A.
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	plications that cause	ed the death. Do not en							211	Approximate	9
	Physician		Immediate Cause (Final		line. NOSCLEROT								Interval Beth Onset and C	Death
	/Medical		disease or condition resulting in death)		s a consequence of):	10	ME	ויייוט	racu	CPV V	156,136	+	JETTE	۷
	Examiner		Sequentially list conditions	b										
. 0	sit ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	s a consequence of):									
Mp	and and I-tran	хац	Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of):									-
8760,	or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	dical E		(,									
687	ificate g phy: is the	edic		a										
Вох	eath certific attending p for use as t	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		7 =					23d. Date	of deliv	ery	
	ne deatl the atte	Completed by Physiclan/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of death 5	☐ Ectopic pre☐ Other <i>(sp</i> e					Mont	h	Day Y	'ear
P.O.	that the de led by the detached	hys	9 Unknown							T				
	ires tha signed I be det	by	Part II. Other significant conditions A DENO CALCINE		COLON 5		•	in Part I.	J	23e. Did tot	oacco use contrib		ne cause or de pably 4 □ U	
50	law requires as been sign 2 should be	ted	A DELLO CHATCHOC	myr or	COLUN,	211 10		0110.		1016				
ခွင	elaw hast	현		-						24a. Was a autops perforr	n 24b. W	ere auto or to co ath?	psy findings a mpletion of ca	available ause of
<u>a</u>	Iclan: The certificate ector, pag									1 ☐ Yes 2	2 (J2 /No 1		2 🗆 No	
<u>ڄ</u>	sicial certir	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:			Othor			(Check only on	<i></i>	1		
of	ding Physician: The n. After this certificate hi funeral director, page	. To	27. Manner of Death	1 ☐ Inpa 28a. Date of In (Month, D			c. Injury a Work?				ence 6 Other		fy)	
<u>o</u>	nding Fith.: After e funera	tioi	1 Matural 5 ☐ Pending 2 ☐ Accident investigation		Pay, Year) Injury	М		s 2 N	0					
Division of Vital Records,	Atte	Certification:	3 ☐ Suicide 6 ☐ Could not I	28e. Place of In	njury - At home, farm, str etc. <i>(Specify)</i>	eet, factory, o	office		28	3f. Location (St City or Town	reet and Number	or Rura	al Route Num	ber,
	tal or rs afte al Dii	Cer		Danang	, (open,)						, orare)			
	Hospi 24 hou Funer rtely fill	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	miner: On the basis	t of my knowledge, deat of examination and/or in	h occurred a vestigation, i	t the time, n my opin	, date and nion, death	l place, a h occurre	nd due to the c d at the time, d	ause(s) and mar ate and place, ar	ner as s id due t	stated. o the cause(s))
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Mec	29b. Signature and title of certifier	and manner	nateu.	29c.	License n	number		2	9d. Date signed	Month,	Day, Year)	
	-s-o		1 /mil/1	Villar	e hus		D311	136			MARCH	12	7009	7
	10		30. Name and address of person who			Print)					racer	1)	2-1	
	12		BRIAN C- W	ALIACE	mo 9005	Ku	CBR	21DE	RD	BALT	MARCH IMELE,	MD	2123	6
	Sta Registr		31. Date filed (Month, Day, 2009	32. Regis	trar's lignature				/					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 03 **Physician** 7: 34 PM THOMAS VAN HERMAN KIMBALL, SR. 12 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE BALTIMORE CIT Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Nov. 13,1928 6 Sex **Funeral** Days Hours 1**X** M 2□ F Director 215-24-0810 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or items 23a or 28a-f sh Examiner must be notified: 1⊠Yes 2 No BALTIMORE Director MARYLAND 10g. Citizen of What Country? 10e. Street and Number LYNDHURST 312 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 NYes 2 No If Yes, Give 3-30-51 Year or Dates: 12-30-53 1 Never Married 2 Married 1 □Yes 2 No Maryland 21215-0036 Specify: BLACK 3 M Widowed 4 □ Divorced "natural", Completed the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. POSTAL SERVICE EMPLOYEE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be KIMBALL CHARLES SMOTHERS Health and Menta tem 27 Is marked other traumatic e MAZIE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1019 QUEEN AVE., SALISBURY, MD 21801 KIMBALL JR. (SUN) if item 27 or other t Saltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages ' 1 ■ Burial 2 □ Cremation 3 □ Removal from State Department or Important: If any Injury or once. ARBUTUS MEM. PARK 03/20/2001 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
505EPH H. PROWN JR. FUNERAL HOME
2140 N. PULTON AVE., BALTIMORE, MID 2121 21. Signature of Funeral Service Licensee), lleams 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chronic obstructive pulmonary year **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to infinitellate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Directo for as a consecutivo of Hospital or Attending Physiclan: The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of): attending physician for use as the burla Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) Division of Vital Records, P.O. cate has been signed by the page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Gastrointestinal bleeding 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Fibrillation 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was an autopsy performed?
Yes 2 No certificate 1 ☐ Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2□No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 □Yes 2 □ No within 24 hours after death. To the Funeral Director: A investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29c. License number *P*22.540 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier CRESIDENT PHYSICIAN) NPI 1992913735 TIMOTHY P. CHIZMAR, MD

10x1

Registrar

TIMOTHY 31. Date filed (Month, Day, Year) State

CHIZMAK, MID 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TIMETHY P. CHIPWAF, MD 22 SOWN GREENE ST. BAITIMORE MD 21201

	-	For State Registrar	State of Maryland		artment of H tificate of L			ene ZU (. No.	J9 U821	U
Physicia /Medic		1. Decedent's Name (First, Middle, Last MARAARET	E.		Koutso	WBOS	2. Date of Death Month March	14 2	3. Time of Death 009 1347P	
Examin)	4a. Facility Na (If not institution, give The Johns Hopkins Ho	ospital		4b. City, Town, or Baltimore	City		4c. County of		
Funeral Director		5. Social Security Number 6. Sec. 278 - 40 - 0697 - 1	7. Age (In yrs. las.	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr. Hours Min			9. Birthplace (State or Forei Country) OH	gn
Maryland -f show ed at		10a. State 10b. County OH Mahoning		Town or Lo	cation Campbe	211			10d. Inside City Lim 1X Yes 2 □ 1	
death with the Maryland ims 23a or 28a-f show must be notified at	al Director	10e. Street and Number 490 Neoka Drive	<u> </u>		10f. Zip-Code 4440)5	10g	. Citizen of Wha	_	
U36 Jrs after It, or ite	by Fui	11. Marital Status 1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2X No	spanic Origin? (n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		American Indian, White, etc. White	
7 215-0036 within 72 hours aft ene. than "natural", or the Medical Examin	Completed	15. Decedent's Ec (Specify only highest grad Elementary/Secondary (0-12)		(Give life. i	dent's Usual Occup kind of work done o DO NOT use retired,	during most of wo)		6b. Kind of Busi		-
yland 21 ould be filed wi Mental Hygien arked other th attic event, the	To Be Con	12			Homemaker		ame (First, Middle, Ma Rusinko	Own Ho		
Ma nd 2 s alth ar 27 is r trau	_	19a. Informant's Name/Relationship (7 Angelo Koutsoubo	ype. Print) os / Husband		,		Rural Route Number,			
		20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Specify	Removal from State cer.	netery, crei	osition (Name of matory or other plac Catholic (Date 20 20/2009		ville, OH	
Baltimo permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens Doubta	1. Marshall		1501 East	. Steve Fort A	ns Funeral Venue, Ba	Ltimore	MD 21230	
Physician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. a. LEFT Hea				ac or respiratory arres	it,	Approximate Interval Between Onset and Death	
Medical cate pe executed physician and stree burial-transit street	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseque c. Due to (or as a conseque d.	nce of):	Fairur Very Di	iseare			9 Days	
Sox 6 ath certificate of the control	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown	23c. If yes, outcome of pregnand 1 Live birth 2 Fetal of the pregnant at time of dead of the pregnant at time of the pregna	leath 3	Ectopic pregnanc	у	15741 143 NO	23d. Date Monti		
cords, P.O. E		Part II. Other significant conditions of	ontributing to death but not result		ụnderlying cause gi	ven in Part I.	23e. Did toba		oute to the cause of death?	
	Completed by	Endometrial C	arcinoma	•			24a. Was an autopsy performe	ed? pr	ere autopsy findings availal or to completion of cause eath? Yes 2 SANo	ble of
Vita iclan: sertifica rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 X No	Hospital: V	D/Outpeties	nt 3 🗆 DOA Oth	or:	eath <i>(Check only one)</i> Home 5 🗆 Residen	oo €□Othor	(Specify)	
on of ing Phys I. Affer this of funeral di	ion: To	27. Manner of D ath 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Injur Work	y at	28d. Describe how			
Division of Vital Rec To the Hospital or Attending Physician: The law within 24 hours after death, To the Funeral Director: After this certificate has t completely filled in by the funeral director, page 2	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined		ie, farm, sti			28f. Location (Stre City or Town,		r or Rural Route Number,	
e Hospital 124 hours e Funeral	edical C	29a. Certifier (check only one) Certifying Ph	ysician: To the best of my knowledge. On the basis of examination and manner stated.	edge, deat on and/or ir	h occurred at the tirn nvestigation, in my c	me, date and pla opinion, death oc	ce, and due to the cal	use(s) and man te and place, a	ner as stated. nd due to the cause(s)	
To the within To the compl	Me	29b. Signature and time of certifier	M			5 — 00		d. Date signed (Month, Day, Year) 14, 2009	
4		30. Name and address of person who ANNA BP01		23a) (Type	, Print)	600	North Wolf	e St, Balt	imore, MD, 212	:87

Registrar

State Sistrar MAR 1 7 2009

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar		State of I	nai yiai i		rtificate o			ientai riy	Reg. N	70113	08271
0	Physicia		1. Decedent's Name	e (First, Middle, L							2. Date of De Month		ay Year	3. Time of Death
	/Medic	_	Jack	Harriso	n Kil	ian					March	n 13	2009	8:00 P M
	Examin	er			ive street and number	er)		4b. City, Town					c. County of Death	
A CO	<u> </u>		5. Social Security N		d Living	Age (In yrs. I	last hirthday	Sever		ark der 24 Hrs.	8 Date of Bir		nne Arun	
U	Funeral Director		579-20-36	528	1 XX M 2□F	83	Yrs.	Months Day			8. Date of Bi (Month, Da 8–18–1	925.	r) Cou	place (State or Foreign ntry) SOURI
	and w	-	Usual Residence of 10a. State	10b. County		10c. City	, Town or Lo	ocation						10d. Inside City Limits
	Mary -f sho fied a	to	MD	Anne A	rundel	Gl	en Bui	nie						1 ☐ Yes 2 🛣 No
	nr 28a	Director	10e. Street and Nu	mber				10f. Zip Code				10g. C	Citizen of What Cou	intry?
	th wit	ョ	400 Cen	tral Ave	nue			2106	1			U	ISA	
	r dea	Funeral	11. Marital Status		12. Was Decede Armed Force	s?	S. 13.	Was Decedent of If Yes, specify C	f Hispanic Jban, Mex	Origin? (Sp dican, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Ameri Black, White	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ∏Never Marr 3 🙀 Widowed	ied 2 Married 4 Divorced	1 ☑ Yes 2[If Yes, Give Year or Date] No s:		1□Yes 2XIN	o Spe	cify:			Specify: whi	te
5-0	72 hd 'natu dical	Be Completed	(Spec	15. Decedent's l	Education rade completed)		16a. Dece (Give	dent's Usual Occ kind of work dor DO NOT use reti	upation e during i	most of work	ing	16b.	Kind of Business/I	ndustry
121	12 should be filed within h and Mental Hygiene. 7 is marked other than " traumatic event, the Mec	g I	Elementary/Seco	ondary (0-12)	College (1-40	or 5+)		curity	rea)			A	uto Indus	stry
2	filed v Hygie ther i	ပ္သ	17. Father's Name		st)				18. M	other's Nam	e (First, Middle	, Maide	en Surname)	
an	d be ental ced o	To Be		Harrison					G]	Ladys	Carro	1	Abernathy	7
ary.	shoul nd M marl	-	19a. Informant's N	ame/Relationship	(Type. Print)		19b. Maili	ng Address (Stre	et and Nu	ımber or Rui	al Route Numb	ber, City	or Town, State, Zi	p Code)
Ž	1 and 2 Health a em 27 is		Mrs Caro	l Zeman/	daughter		400 0	Central	Ave.	Glen	Burnie	MD	21061	
ore,	es 1 a of He fitem		20a. Method of Disp		☐Removal from Sta	20b. P	lace of Disp emetery, cre	osition (Name of matory or other p	lace)	1	Date		Location - City or T	
ij	Pages ment of h tant: If its jury or or			5 Other (Spec	cify)	Met		ematory		1	/2009		onsville	
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of	Service Lip	ensee	M013	64 4	2. Name and Add 21 Crain	fress of Fa	SE G	rkley-F Len Bur	Rudd nie	ick Fune MD 21061	cal Home PA
			23a. Part1. Enter t	the disease, or co	mplications that causely one cause on each	sed the death	n. Do not er	ter the mode of o	lying, sucl	n as cardiac	or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause disease or condition	(Final	· One	imo	. 11.00							Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):											
	Examine	-	Sequentially list co	onditions,	b. adv	an Cl	2 d	armei	7770	7				years
B	ted	nine	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	nmediate erlying injury	Due to (or	as a consequ	derice or,						4	/
1	execunate and al-train	Examiner	that initiated events resulting in death)	s Last	c Due to (or	as a consequ	uence of):							
68760,	eath certificate be executed attending physician and for use as the burial-transit	edical			d									
	rtifica ng ph		IE EEMALE:											
Вох	ath ce ttendii or use	an/l	IF FEMALE: 23b. Was deceder in the past 12		23c. If yes, outcom 1 ☐ Live birth	n 2 ☐ Feta	I death 3	□Ectopic pregna					23d. Date of deliver Month	/ery Day Year
	Attending Physician: The law requires that the death certificate be executed death. death. ector: After this certificate has been signed by the attending physician and y the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/N	1 ☐ Yes 2 l 9 ☐ Unknown	□No	4∏Pregnan 9∏Unknow		eath 5	Other (specify)						Jay Tour
Vital Records, P.O	s that ned by e deta	y Ph	Part II. Other signi	ficant conditions	contributing to deat	h but not resi	ulting in the	underlying cause	given in P	art i.	23e. Did	tobacco	o use contribute to	the cause of death?
rd	w require been sig should b	ed t	chron	ic ob	STYMO	true	Ru	lmona.	ry	disea	age 10	Yes	2 No 3 Pro	bably 4 Dunknown
ecc	e law re has be je 2 sho	plet	Nype	rten.	5100		V				24a. Was	psy	prior to c	opsy findings available ompletion of cause of
E.	The ate h	Som	perion	eral	Vasc	ula	1 d.	seac	e		perf	ormed? 2☐	death?	2□ No
/ita	ician: Th certificate ector, pag	Be	examiner?	rred to medical	Hospital:			1,		lace of Deat	th (Check only	one)		assisted
	Physical this call dire	To.	1 Yes 2		1 ☐ Inp		ER/Outpatie	0[] 507.		Nursing Ho	ome 5 ☐ Res 28d. Describe		6 DOther (Spec	ify)
on	ding F n. After funer	ion	1 Natural 2 ☐ Accident	5 Pending investigati	(Month,	Day Year)	Injury	1	njury at Vork? ☐ Yes	2□No	Zod. Describe	11011111	gary occurred	0
Division or	Atten deat	fica	3☐ Suicide	6 Could not	be 28e, Place of	injury - At ho	ome, farm, s	treet, factory, office	ce		28f. Location	(Street	and Number or Ru	ral Route Number,
Ö	s after al Dire	Certification:	4 ☐ Homicide		building	etc. (Specif	y) 				City or To	own, Sta	are)	
_	To the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical (29a. Certifier (Check only one)		Physician: To the be aminer: On the basi and manner	s of examina								
10	To the within 2 To the comple	Me	29b. Signature/and	title of certifier	1 1		- 4 %	29c. Liq	ense numb	oer	25	29d. [Date signed (Month	, Day, Year)
			1				MD		00	010	グリ	3	-16-	2009 21105
			30. Name and add	ress of person wh	no completed cause	of death (Item	n 23a) (Type	, Print)	1	11	11	.11	1- 10	21175
		(Annit. 31. Date filed (Mor	erKille	Incol	SOU Istrar's Signa	Vete	ransti	WY	Mi	cersi	Me	e /VI) villy
	Sta Registi		o i. Date filed (MO)	IAR 172	009	MA A	1. 1	ares	0					

			For State Registrar			f Maryl	land / De	oartmer ertifica			nd M	1ental ⊦	lygie Reg.	0.0	09	0.8	272
	Physici		1. Decedent's Name William L									2. Date of Month March		Day 2009	Year	3. Time of 5:45	
	/Medic		4a. Facility Name (li Gilchrist	f not institution	, give street and nu			4b. City		Location of		racon		4c. Count	y of Death		
	Funeral Director		5. Social Security No. 216 42 842	27	6. Sex 1 ⊠ M 2□ F	7. Age (In	yrs. last birthda Yrs.	y) If Unde Months	r 1 Year Days	If Under 24 Hours	4 Hrs. Min.	8. Date of (Month,	Birth Day, Ye	ear) 1942	9. Birthp Cour Mary	place (State ntry) land	or Foreign
	Maryland a-f show	tor	Usual Residence of 10a. State Maryland	10b. County Baltin	ore	10c	: City, Town or								1	0d. Inside C	City Limits
	th with the 23a or 28¢	Funeral Director	10e. Street and Nun				10f. Zi	Code 2122	21			10g.	. Citizen of USA	What Cour	ntry?		
900	Deficient Piges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modifiel Eventinar must be realth of an once.	d by Funer	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed	in U.S. 1	13. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □Yes 2X No Specify:					No-	Bla	ack, White, of the White, of t	etc.	or Foreign Other Limits 221 te tween Death Call the tween Deat			
7	Z I Z I 3-UU30 d within 72 hours aft giene. er than "natural", or ine "testien Exami	Completed by	(Special Special Speci		d's Education of grade completed) College (1	-4or 5+)	(Gi	. DO NOT L	ork done o se retirec	durina most c		ing				Business/Industry Manufacturer	
	Maryland d 2 should be filed the and Mental Hyg 7 is marked othe traumatic event,	e	17. Father's Name (Ferdinand	Klapka	<u> </u>					18. Mother's		e (First, Midd Llman	lle, Mai	den Surnai	me)		
	and 2 sho and 2 sho lealth and m 27 is ma her trauma		19a. Informant's Na Michelle I	Evans (1909	Jean	Cou	and Number	est	Hill,	Ma	rylan	d 210	50	
15Am	t. Pages 1 tment of F tant: If ite		4 ☐ Donation	☑ Cremation 5 ☐ Other <i>(S)</i>			Db. Place of Dis cemetery, ci	Crema	tory	Inc.3	/20,		Ba.	ltimo	•	arylar	
7	Dal permi Depar Impor any ir		21. Signature of Fu	W.B	vikrusko					s of Facility Laster Saster					aryla	nd 212	221
2009 5	Physician //Medical Examiner		shock, or hear Immediate Cause (disease or condition resulting in death)	rt failure. List Final n	Due to (ach line. A 377 (or as a con	sequence of):					or respiratory	/ arrest			Approximatinterval Bei Onset and	tween Death
urth 14,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical Examiner	d														
_ C	that the death certificated by the attending p detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1											*	Year		
MIIIIM Postale D	w requires that s been signed is should be det	þ	Part II. Other signifi	cant condition	ns contributing to de	eath but not	resulting in the	underlying o	ause give	en in Part I.						ne cause of c	
38	The law recate has be cate has be page 2 sho	Completed										24a. Wa au pe 1 □ Yes	topsy rformed	12	Were autoprior to condeath?	psy findings mpletion of c	available ause of
75 X	ysician: The is certificate director, pag	To Be	25. Was case referrence examiner?		Hospital: 1 ☐ I	npatient 2	2 ☐ ER/Outpati	ent 3□D	Othe			n <i>(Check onl</i> me 5 ☐ Re		e 6 🔊 Ott	her /Specifi	4nc	2118
4199	Attending Physician: r death. ector: After this certific by the funeral director, i	Certification: T	27. Manner of Death 1 Natural 2 Accident 3 Suicide	5 ☐ Pending investig	28a. Date (Mont	of Injury h, Day, Yea	r) 28b. Time Injury	of M	28c. Injury Work 1 □	at at	2	28d. Describ				, 11031	762
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		4 🗌 Homicide	determi	ned 28e. Place	ng, etc. (<i>Sp</i>				no data and		28f. Location City or 7	own, S	tate)			iber,
	To the Hos within 24 h To the Fun completely	Medical	(Check only one)	2 Medical I	Examiner: On the ba	asis of examer stated.	nination and/or	investigation	i, in my o	oinion, death	occurr	ed at the tim	e, date	and place,	and due to	the cause(s	3)
_	To To Con	2	29b. Signature and t	title of certifier	000			29	License		_				16,2		
			30. Name and addre	ess of person	who completed caus	e of death (Item 23a) (Type	e, Print)	00	4395	,		1711	IFLET	1012		
3	Sta	te	31. Date filed (Month	DUBL h, Day, Year)	who completed caus RMAN; M 7 2009	D 65 egistrar's Si	ignature &	CHAR	iis	ST, 8	UIR	209	E	BALTI	ment	, MAZ	4204
7	Registr			MAR!	7 2009	Geneer	N B.	Han									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 01:13AM 2000 Joseph Edward Lane, Jr. ARCH /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Town, or Location of Death Examiner 105 pital 1more 25 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) . Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 XM 2 □ F Yrs. Director 214-90-8371 MAR 6, 1966 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Evaniner must be notified at 1 □Yes 2 No Director MD Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21228 USA Completed by Funeral 2 McTavish Avenue 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 27 No Specify. 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withii nent of Health and Mental Hygiene. unemployed N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 is marked of traumatic ever Joseph E. Lane Margaret Piquet 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr once. Patricia Ellen Lane/Wife 2 McTavish Ave Catonsville. MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 3/17/09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee C. Todd Dring MacNabb Funeral Home, P.A. 301 Frederick Rd Catonsville, MD 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the IF FEMALE use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 - Ectopic pregnancy Month Day Year 5 Other (specify) sate has been signed by the page 2 should be detached 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 2 No 3 Probably 4 denknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 □Yes 2 No Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ho 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical completely and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			Please amend #8 Per F 1_ State	Type or Prin H G889 3/1 State of Ma	It in Blac 1 7/09 Ji aryland / I	k Indelib Departme Certifica			All Copies Mental Hy		egible.	08274	
			Registrar 1. Decedent's Name (First, Middle, La.	at)		Certifica	ile oi	Death	2. Date of D	Reg. No.		3. Time of Death	
П	Physici	an	T. Decedent's Name (First, Middle, La.	51)					Month	Day	Year		
mail of the last	/Medic		4a. Facility Name (If not institution, giv	re street and number)		4b. Cit	v. Town. o	r Location of Deat	h		2009 County of Death	20:05	
	Examin	er						lskown			actions		
	Funeral		5. Social Security Number 6. S		e (In yrs. last bi	7 77 77	er 1 Year			irth			
L	Director		228.20.5154	ØM 2□F	81	Yrs.	S Days	Tiours IVIIII.	05 05	1927		place (State or Foreign htry) V.A	
	pu.		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location			' '		T	10d. Inside City Limits	
	faryla f sho	ō		more			Jak					1 □Yes 2 No	
	the N 28a-1 notifie	rect	10e. Street and Number		001	_	Zip Code			10a. Citiz	en of What Cou	ntry?	
	72 hours after death with the Maryland natural", or items 23a or 28a-f show diest Examiner must be notified at	Funeral Director	2131 Holder Au	lenue				1207			USA	•	
	death ms 2	nera	11. Marital Status	12 Was Decedent I	Ever in U.S.	13. Was Dec	edent of I	lispanic Origin? (S an, Mexican, Puer	Specify Yes or N	0- 1	4. Race - Ameri		
9	after or ite mine		1 Never Married 2 Married	Armed Forces? 1 Yes 2 Yes If Yes, Give	No	1 □ Yes		Specify:	to Rican, etc.)		Black, White,		
003	ural",	d by	3 Widowed 4 Divorced	Year or Dates:							1310		
<u>-</u> 5	"nat	lete	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a	 Decedent's Us (Give kind of v life, DO NOT 	vork done	during most of wor	rking	16b. Kin	d of Business/In	dustry	
21215-0036	e filed within al Hygiene. I other than " vent, the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	T .	gger	•		Coa	st Gua	rd Yard	
	il Hygi other vent, I	e C	17. Father's Name (First, Middle, Last,)	,		33	18. Mother's Nar	ne (First, Middle	e, Maiden S	Surname)		
/lar	Mental Mental arked o	To Be	Will Chester					Paul	ine La	iwrer	nce		
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	and lealth m 27 her tr		Margaret Frances Lawr	ence/NHe	100			iller Gara				101	
altimore,	ges 1 If ite or ot		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State		of Disposition (Nery, crematory of			Date		ation - City or To		
ţi	permit. Pag Departmen Important: any injury once.		4 Donation 5 DOther (Special		Model	awn Cen			18/09		dlawn,		
Ba	permit. Pages 1 Department of F Important: If ite any injury or of		21. Signature of Funeral Service Licer	120	_	22. Name	and Addre	s of Facility VQ				MD 21133	
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused	I the death. Do	not enter the m	ode of dyi				VIS UVO I	Approximate	
	Physician	0.0	Immediate Cause (Final					V			3	Interval Between Onset and Death	
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687	death certificate le attending physicate for use as the tendents.	Physician/Medica		d									
Box	n cert ending use a	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		h 0□ Estani				23d. Date of delivery			
	death	sicia	in the past 12 months? 1 □Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown		h 3 ☐ Ectopi 5 ☐ Other					Month	Day Year	
P.0.	N requires that the described should be detached	hys	9 Unknown						00 8:1				
	res th signed be de	þ	Part II. Other significant conditions	•	-							the cause of death? bably 4/2 Unknown	
0.00	law requires as been sign 2 should be	eted	Resp Inchery	Ma-lux	-								
Division of Vital Records,	S 38	Completed	Atres MAN	· / late = -						s an opsy formed?	24b. Were auto prior to co death?	opsy findings available ompletion of cause of	
a	n: The ficate h r, page		05.14	T					1 □ Yes	2.₽No	1 ☐ Yes	2.☑No	
ξ	Physician: this certific al director, I	Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2 D EB/O	utpatient 3 🗆	DOA Oth	26. Place of De			Other (Speci		
of	g Phy er this eral d	μ	27. Manner of Death	28a. Date of Inju	iry 28b.	Time of	28c. Inju Woi	4 LI (Adioning I	28d. Describe			(V)	
ion	Attending it death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investigatio	(Month, Da	y, rear)	Injury M		k? Yes 2□No					
Vis	r Atte er dea recto	Certification: To	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	26e. Place of inj	ury - At home, fa c. (Specify)	arm, street, fact	ory, office			(Street and wn, State)	Number or Run	al Route Number,	
۵	ital or irs afte ral Dir												
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical		hysician: To the best miner: On the basis o	f examination a								
	To the I within 2 To the I сотпре	Med	29b. Signature and title of certifier	and manner sta	ated.		29c. Licens	se number		29d. Date	e signed (Month,	Day, Year)	
	FSFö		100									62	
			30. Name and address of person who	completed cause of d	leath (Item 23a)	(Type, Print)	U	2908	- 3	- Cu	ch	3 2004	
			Allan J- Ch.	1005 -	40	540	0	10 CCU.	+ Ro	00	2113	3	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	540							
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			For State Registrar	State of Maryla	-	artment of F rtificate of			giene Reg. No. 200	9 08275
			1. Decedent's Name (First, Middle, Last)				-	2. Date of Dea		3. Time of Deeth
	Physici /Medio		Charles William	Latham,	Jr.			03		009 9:32P M
	Examin	er	4a. Facility Name (If not institution, give s.	treet and number)		4b. City, Town, o		ath	4c. County of I	
			Dove House 5. Social Security Number 6. Sex	7 Ago /le ve	s. last birthday)	Westmi If Under 1 Year		rs. 8. Date of Birt	Carro	
	Funeral Director		265-80-5704	7. Age (In yr.	60 Yrs.	Months Days	Hours Mi		Year)	Birthplace (State or Foreign Country) WV
	_		Usual Residence of Decedent					10 11	1740	
	how	_	10a. State 10b. County	10c. C	city, Town or Lo	cation				10d. Inside City Limits
	Ba-f s	cto	MD Baltimore	City I	Baltimo		,			1 □Yes ※□No
	ith th	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	-
	s 23a	eral	1303 Glyndon Avenu		10 10	21223		(Capaity Van or No	U.S	
	items ?	-un	11. Marital Status 1 ☐ Never Married 2 ☒ Married	 Was Decedent Ever in land Armed Forces? 1 ☐ Yes 2 No 	L L		an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	Black, V	American Indian, White, etc.
920	al", or	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2∰No	Specify:		Specify:	White
2-0	be filed within 72 hours after death with the Maryland that Hygiene. dother than "natural", or items 23a or 28a-f show event, the Madical Evanimar must be notified at	Completed	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occup	nation	nrkina	16b. Kind of Busin	ess/Industry
21	thin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	`life.	DO NOT use retire	d)	Orking	m	1.
21	ed wi	ပ်	11		111	ıck Drive		(P*1A 0 41-4-41-		king
and	be fill Hall Hed otl	Be	17. Father's Name (First, Middle, Last)	C			Betty	ame (First, Middle, McNear	,	
Ξ	12 should be fi h and Mental I 7 is marked of rraumatic eve	은	Charles Latham, 19a. informant's Name/Relationship (Typ		10h Mailir	na Address (Street	,		or, City or Town, Sta	ato Zin Code)
Ma	0 4		Mrs. Betty Reynolds			Box 568		rna Park,		
ē,	s 1 ar		20a. Method of Disposition	20b.		sition (Name of natory or other place		Date	20c. Location - Cit	
Ë	Page Tent of Int: If		1 ☐ Burial 2 🖾 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		Cremato		-16-2009	Glen Bu	rnie, MD
Baltimore, Maryland 21215-0036	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service License	9				_	Funeral &	Cremation Srv
<u>m</u>	8 3 E 8 3		K Consider	MUC MOLL	MG P	.A., 1 2n	d Ave SI	W Glen B	urnie, MD	21061
*	Cate be executed cate be executed physician and physician and the prival-transit categories.	dical Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e cause on each thre.	quence of): ALC quence of): ALC	Dirate Encepi ail ure	halupu	rest		Approximate interval Between Onset and Death
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the bunal-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o 9 Unknown	tal death 3	Ectopic pregnand Other (specify)	sy		23d. Date o Month	
of Vital Records, F	luires that n signed I lid be det	þ	Part II. Other significant conditions conf	ributing to death but not re	sulting in the u	nderlying cause giv	ren in Part I.			ite to the cause of death? Probably 4 X Unknown
000	tw requir s been s s should	Completed		, (3				24a. Was a	an 24b. Wer	re autopsy findings available
Ä	The lar	шо						- autop perfor 1 □ Yes	med? dea	r to completion of cause of th? Yes 2.27No
ita	siclan: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of D	eath (Check only or	/	-1-1-
>	ys dir	To B	examiner? 1 ☐ Yes 2 ►No	ospital: 1 ☐ Inpatient 2 [☐ ER/Outpatie	nt 3 □ DOA Oth	ner: 4 🗆 Nursing	Home 5 ☐ Resid	lence 6 XOther ((Specify) HOSPICO
	ding Ph h. After thi funeral	ii.	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	Wor		28d. Describe h	ow injury occurred	
sio	Attending ir death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	00 81			Yes 2 □ No	200 1		
Division	tal or Atra after dal Direct	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, office		28f. Location (S City or Tow		or Rural Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the f	Medical		ician: To the best of my ker: On the basis of examinand manner stated.						
	Vithi Vithi Com	M	29b. Signature and title of certifier	1		29c. Licens	se number		29d. Date signed (A	Month, Day, Year)
			1 OXF GARA	1/1/0		25	5625		March L	1,2009
	10		ROUGE FOUGH	npleted cause of death (It	from orc	Print GCCS	te 200,	Baltin	de Mo	2(20/
	Sta Registi		31. Date-filed (Month, Day Year)	32. Registrar's Sign	nature ba	Kel	(

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day AOO **Physician** RichettA /ANC /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Future CARE Charles Village BALTIMORE 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** ViRgiNiA Months Days 1 □ M 2 🗹 F 220-30-5280 Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location show traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director 28a-f 10g. Citizen of What Country? 10e Street and Number or items 23a or Funeral Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Mo Specify: \$ 3 Widowed 4 ☐ Divorced and Mental Hygiene. Is marked other than "natural", Completed 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home HOME MAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JeremiAh ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LANE GRANDCHOCK Department of Health Important: If item 27 any Injury or other trong once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dundalk md. Y Cemetery 3-13-09 AVIS JV. FUNERA I HOME 21. Signature of Funeral Service Licensee BAL VO. Md.2123, 007 EASTERN AUE. 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) yav. Physician Coronar Due to (or as a consequend of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director; After this certificate has been signed by the attending physician and burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐Yes 2 ☐ No Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) is certificate has been signed by the director, page 2 should be detached 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2. No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide within 24 hours at To the Funeral D completely filled in 1 x ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier \$ 57088 Than Poon, mi 2000 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pory PLACE #601 BALTIMORE MD 301

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32 Registrar's Signature

landine t 19-01850 JNK UNK	. , (pe or Print i ate of Maryla						•	009 082			
		I- For State Registrar		Certi	ficate of	Death			Reg. No.	000 002			
Physicia Medical Examir		Decedent's Name (First, Midd CLAUDINETTE LE	*					2. Date of De Month March 5	Day Yea	3. Time of Death 0915 hrs			
		4a. Facility Name (if not institution 3921 Norfolk Avenue		umber)	4	b. City, Town, or Baltimore	r Location of		4c. County o	of Death			
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last	t birthday)	If Under 1 Yea	ar If Under	24Hrs. 8. Date of B	Birth (MM/DD/YYYY	9. Birthplace (State or Fore			
Director		unk	1M 2XF	47	Yrs.	Months Day		Min.	28, 1962	Country) MD			
. A		Usual Residence of Decedent 10a. State 10b. County			own or Location	\n		1001	20, 1302	10d. Inside City Limi			
ind show any nce.	5	MD			IMORE	<i>7</i> 11				1 X Yes 2 N			
Maryla r 28a-f	Director	10e. Street and Number		•		10f. Zip Code			10g. Citizen of Wh	at Country?			
E 23		3921 NORFOLK A	12. Was Dec	12. Was Decedent Ever in U.S. 13. Wa				n? (Specify Yes or N		- American Indian, Black,			
9 5 6	Funeral	1 Never Married 2 M	1 Yes	2 X No				Puerto Rican, etc.)	White				
urs aft. tural'	d by	3 Widowed 4 X Div 15. Decedent's Education (Spe	vorced If Yes, Give Yes or Dates: ecify only highest gra		6a. Decedent		ation (Give kir	nd of work done	16b. Kind of Bus	BLACK siness/Industry			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filled within 72 hours after Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural" injury or other traumatic event, the Medical Examiner	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mo	st of working life	e. DO NOT us	se retired)		-			
d within ygiene.	E	12TH 17. Father's Name (First, Middle	, Last)		ADMII	NISTRAT:		Name (First, Middle	HOSPI , Maiden Surname)				
21215-0036 but be filed within 7 Mantal Hygiene, marked other than icevent, the Medica	Be	ARTIS LEACH, S						M. WILLI		······································			
MD 2 d 2 should th and M n 27 is m: numatic e	위	19a. Informant's Name/Relations	, , , , , , , , , , , , , , , , , , , ,	,				er or Rural Route N	umber, City or Towi				
e, N 1 and 2 Health Fitem 2		TIFFANY WILSON 20a. Method of Disposition		20b. Pla		N. HILE		Date		21216 City or Town, State			
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Burial 2 X Cremation 4 Donation 5 Other S		rom State	ARDEI	VT		03/12/200	9 HANOVE	IR, MD			
Balti permit. Departr Import injury		21. Signature of Funeral Service	Licensee	1,			s of Facility	WESLEY CH	AVIS, JR.	FNRL. HM.			
Physician		23a. Fail I. Enter the dy ease, or	r complication that of	caused the death. D	o not enter th	007-09 I e mode of dying	FASTERI , such as car	N AVE., B diac or respiratory a	ALTIMORE , irrest, shock, or hea	art Approximate Interv			
/Medical Examiner		failure. List only ne cause Immediate Cause (Final disease	a. Narc	otic (mor	phine	and met	hadone	e) and al	cohol int	Between Onset an Oxication			
		or condition resulting in death)	Due to (or as a	a consequence of):									
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		a consequence of):									
sit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequence of):									
2 2 3	- 1	X UNPENDED	DED AMENDED 23a,27,28a-f,perME, g889 3/18/09 TT										
760, cate be	sician/Medica	IF FEMALE: 23b. Was decedent pregnant in t	ho	outcome of pregna	incy				23d. Date of	delivery			
Box 68760, e death certificate be the attending physic ed for use as the bur	ician	past 12 months?	4 Pregi	birth nant at time of deatl	h ====================================	al death 3 er (Specify)	Ectopic p	pregnancy	Month	Day Year			
, BO) he deatl	Physi	1 Yes 2 No 9 V Un	aOIIKII					1 220 Did	1-1				
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. "In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	Š	Part II. Other significant condi	tions contributing t	o death but not resi	uiting in the u	ndenying cause	given in Part			bute to the cause of death? Probably 4 Unknow			
rds,	Completed							24a. Wa		Vere autopsy findings availal			
Reco The lav cate has	E C							per	formed? d	eath? Yes 2 No			
ician; certifi rector,	Be	25. Was case referred to medica examiner?	Hospital:				Othor:	Check only one)		2011			
of Vigg Physical dispersed	임	1 Yes 2 No 27. Manner of Death	28a. Date	of Injury 2	R/Outpatient 8b. Time of Ir		ury at Work?	Nursing Home 5 28d. Describ	Residence 6 ve how injury occurre				
ion (tendin eath.	ation	1 Natural 5 Pen 2 Accident Inve	dina	n, Day, Year) 5/5/09	Fd 9:0) am 1	Yes 2 X	I					
Divis al or Al s after d al Direc ed in by	Certification:	3 Suicide 6 X Cou	ld not be 28e. Plac	be of Injury - At home house	ne, farm, stree	t, factory, office	building, etc.	28f. Location or Town,	(Street and Number State) 3921	er or Rural Route Number, Ci Norfolk - Ave			
Hospita 24 hours Funera rely fills	ခို	29a. Certifier 1 Certifying P	hysician: To the be	st of my knowledge	, death occur	ed at the time, o	date and place	e, and due to the ca	use(s) and manner	as stated.			
Division of Vital To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.	Medical	one) 2 Medical Exa	aminer: On the basis and manner:	of examination and	or investigati	on, in my opinio	n, death occu	urred at the time, dat	e and place, and de	ue to the cause(s)			
	Σ	29b. Signature and title of certifi	er			29c. Licen				ed (Month, Day, Year)			
		30. Name and address of person	who completed care	se of death (Item 21	3a)	0.0	.M.E.		March 6, 20				
			sistant Medical		,	treet, Baltim	ore, MD 2	1201					
Sta Registi	ate	31. Date filed (Month, Day, Year)	2009 32	egistrar's Signature	ba	Ke!							

Amend 19a, perFH 5889 3/17/09 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 19:15 PM LEONARD LEWIN 2009 arc /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** UNION MEMORIAL HOSPITAL BALTIMORE CITY N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 03/30/19 13 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Age (In yrs. last birthday) 1**X** M 2□ F 95 297-40-3990 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show the Medical Examiner must be notified at 1 Y Yes 2 □ No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 830 W. 40TH STREET, #210 21211 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a may injury or other traumatic event, the Purifiest Exprirest must once. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: WHITE Specify: 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) PHYSICIAN MEDICINE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LOUIS LEWIN SARAH ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JONAJAN LEWIN/SON 104 RIDGEWOOD ROAD BALTIMORE, MD 21210 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MAYFTELD CEMETERY 03/14/2009 CLEVELAND HEIGHTS, OH 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** habdomyal daus disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Univerlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 □ Yes 2 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2[1No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nion ordt 31. Date filed (Month, Day, Year) State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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Director	Mary1
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Be Completed

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Physician /Medical Examine

Funeral Director

	Piea	State of			partment of h				egible.					
For State Registrar		State	i iviai yiaii		ertificate of				2009	08279				
1. Decedent's Name	e (First, Midd	le, Last)					ath	Vaar	3. Time of Death					
Spencer	r Mer	rick, II	I				March	16	200 ^{year}	3:45 P M				
4a. Facility Name (// Dove He		n, give street and nu	mber)		4b. City, Town, c	r Location of Death inster		4c. C	County of Death	Ĺ				
5. Social Security N 219-26-62	.73	6. Sex 1 M 2 □ F	7. Age (In yrs.	$^{\prime}1$ Yrs.	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Feb 9,	193	9. Birth Con Mar	nplace (State or Foreign unity) yIand				
Usual Residence of 10a, State	Decedent 10b. County	,	10c Cit	y, Town or	Location				.	10d. Inside City Limits				
Maryland	Worce		100.00		an City					1 ☐ Yes 2 No				
10e. Street and Nur	mber				10f. Zip Code			10g. Citizen of What Country?						
5505 Atl	antic .	Avenue Apt	.404			21842	USA							
11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed		rried Armed Fo	2 X No ve	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black						American Indian, White, etc. White				
(Spec	cify only highe	nt's Education est grade completed) College (1-4or 5+)	(Gir life	cedent's Usual Occup ve kind of work done o. DO NOT use retire ASSESSO1	during most of work d)	ing		e Of Ma					
17. Father's Name Spencer						18. Mother's Name			Surname)					
19a. Informant's N				19b. Ma	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
Katherin	e Merr	ick, Wife		5505	Atlantic	Avenue Ap	pt.404 (Ocean	City,	MD 21842				
20a. Method of Dis	position CyCremation	3 ☐ Removal from	State C	emetery, ci tro C	position (Name of rematory or other pla rematory	nc. 03/1		20c. Location - City or Town, State Baltimore, Maryland						
21. Signature of Funeral Service Licensee Thomas Gregor					Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228									
23a. Part 1. Enter t	he disease, c art failure. Lis (Final	or complications that of tonly one cause on e	caused the death ea pline. (r as a conseq	non	enter the mode of dyi	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death				

Physician /Medical Examiner

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of) Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

2 3 No 1 🗌 Yes 24a. Was an autopsy performed

24b. Were autopsy findings available prior to completion of cause of death?

3 ☐ Probably 4 ☐ Unknown

Year

2 No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice

1 ☐ Yes 2 🗆 No

l	1 Yes 2 N	0
I	27. Manner of Death	
I	1 Natural	5
1	2 Accident	

3 Suicide

29a, Certifier

4 Homicide

25. Was case referred to medical examiner?

9 Unknown

þ

Be Completed

Medical Certification: To

☐ Pending investigation 6 ☐ Could not be

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

and manner stated.

28b. Time of Injury 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

St 307

/		
29b. Signature	and title of	certifier

29c. License number

29d. Date signed (Month, Day, Year)

ress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add

Month, Day, Year) 31. Date filed (Mo.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 1002A Edward C. Murphy III 03-15-2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Stella Maris Timonium
If Under 1 Year | If Under 24 Hrs. Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 X M 2 □ F 69 029-28-5775 12-07-1939 Mass. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Inportant: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Experiment must be notified at once. 1 ☐ Yes 2 X No Director MD Harford Edgewood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3423 Seabrook Ct 21040 Funeral IISA 12. Was Decedent Ever in U.S. Armed Forces? 1 Xes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No 10:02 a.m. ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman Waterproofing Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward C. Murphy, Jr. 15, 2009 Jeanne Proctor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine M. Murphy (Wife) 3423 Seabrook Ct Edgewood, MD 21040 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State $\frac{62}{102}$ -17-2009 | Fallston, MD Highview Mem. Gar. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signatur of Funeral Ser Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** ESOPHAGEAL CANCER /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. End of John of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit Due to (or as a consequence of) Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Ye ar Month Day 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached to ☐Yes 2☐No 9 Unknown 9 I I Inknown EDWARD MURPHY Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform certificate 2X No 1 ☐ Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director, p. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours a To the Funeral D Certifler (Check only one X Nurse Practitione Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Practitioner. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

10

State Registrar SR. DOROTHEA MAHOLLAND, CRNP 2300 DULANEY VALLEY RD.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

33. Registrar's Signature

34. April 7 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TIMONIUM, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10e, 20b per fh g889 3-17-09 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** arch /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner BALTIMOR 1055 W. Joppa Rd. Apt 404 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 124 M 2□ F 7. Age (In yrs. last birthday) If Unde 8. Date of Birth (Month, Day, Year)
OCt. 4,1918 Birthplace (State or Foreign Country) **Funeral** Hours Min. Months Days Baltimore, MD 216-14-4945 90 Director Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 28a-f shov 1 ☐ Yes 2 No Directo Towson MD **Baltimore** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21204 1055 W. Joppa Rd, m Apt. 404 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? ★XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No white Baltimore, Maryland 21215-0036 Specify Specify: **¾**Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within the and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) President/CEO Filterite 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles A. Miller, Sr. Bertha Erck ပ traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any injury or other traur once. P.O. Box 1375, Lakeville, CT 06039 Charles A. Miller, III (son) 20b. Place of Disposition (Name of certainty or other place)

Evans Funer1 Chapel – BelAir 3/17/09 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, MD 22. Name and Address of Facility 16924 York Rd., Monkton, MD 21111 Evans Funeral Chapel & Cremation Services—Monkton 21. Signature of Funeral Service 23a. Part 1. Enter the disease shock, or Heart failure, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus Final disease or condition resulting in death) **Physician** arkera /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tranresulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 - Ectopic pregnancy Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached ed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1☐ Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After or Attending Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide after To the Hospital or within 24 hours at To the Funeral D cal 29a. Certifier TECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thompsens 5 670 32. Registrar's 31. Date file State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** HO JEORUS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Franklin 5. Social Security Number Mare tospita 9. Birthplace (State or Foreign Country) If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours Min. M 2□F Months 317347813 Usual Residence of Decedent Director 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b County 28a-f show th and Mental Hygiene.
?? Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Mexical Examinating the profilled at 1 ☐ Yes 2 No Director IARYLAND BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important; if item 27 is any injury or other trau 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 200 5 ☐ Other (Specify) of Fune al Prvice I censee APRIANDERRY 101 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final nfarctio **Physician** Lyocardia disease or condition resulting in death) /Medical Due to for as a consequence of): Examiner betes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans 105 Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 🗆 Ectopic pregnancy 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural Natural nours after death.
neral Director; A:
filled in by the fu 1 TYes 2 🗆 No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D completely filled i TS Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of cert 29d. Date signed (Month, Day, MU

State Registrar 30. Name and address of person

31. Date filed (Month, Day)

Na

Dr. Eric

DHMH 17 Rev 1/2001

who completed cause of death (Item 23a) (Type, Print)

Franklin

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month March 15, 2009 Year Day **Physician** Jo Mae Mauro 7:40 A.M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Gilchrist Hospice Towson Baltimore County If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MISSISSIPPI 8. Date of Birth (Month, Day, Year) JULY 27,1928 5. Social Security Number 7. Age (In yrs, last birthday) 6. Sex **Funeral** Min. Hours 1 □ M 2 1 F Months Days 80 067-32-4793 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 ☐ Yes 2X No ir than "natural", or items 23a or 28a-f shifty Wedical Evanimer must be notified Director Maryland Baltimore County White Hall 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4563 Amos Road 21161 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 TaNo Specify: If Yes, Give Year or Dates: Specify: Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 is marked other than College (1-4or 5+) Sales Agent Real Estate n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) g and Mental Robert Newton Guy Ellen Sellers traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If item 27 is any injury or other trau Cindy Tutton (Daughter) 4563 Amos Road White Hall, Maryland 21161 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition March₂₀₀₉17, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility Caceful Alternatives Funeral&Cremation Ctr.,P.A. 325 York Road Timonium, Maryland 21093 eace: 2325 Timonium, Maryland or the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Immediate au e (F al disease or condition resulting in death) **Physician** -04 /Medical Due to (or as a consequence of): Examiner Securentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed -transit and Due to (or as a consequence of): burial-Box 68760. physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform page certificate 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one Be Hospital: Other: 4 Nursing Home 5 Residence 2 ANO 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28c. Injury at Work? 27. Manner of Teath 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred ospital or Attending hours after death. 1 Natural 5 Pending 1 🗆 Yes within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Haviker MD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Year 1:10 PM Physician March 2009 /Medical 4c. County of Death Town, or Location of Death Examiner TIMON 9. Birthplace (State or Foreign vrs. last birthday) If Under **Funeral** Min. Months Days 1 □ M 2 □ Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Ne deal Exh. in a must be notified at once. 1 os 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code Street and Number venue Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Never Married 2☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) ar, Secondary (0-12) ·S. Postal Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S 19a. Informant's Name/Relationship (Type. Print) (SOM 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 1 KBurial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ulmonan Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner mphy sems the Hospital or Attending Physiclan: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): 3 well (S Box 68760, attending physician for use as the burial neumonia Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Month Day 5 Other (specify) Division of Vital Records, P.O. cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3☑ Probably 4☐ Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 1 No 2 No 1 □Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After 1 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and matrier as stated.

n 24 hours after death.

le Funeral Director: Af bletely filled in by the fur within 2 To the 1

> pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who Incon

State Registrar 31. Date filed (Month, Day, Year) MAR 1 7 2009 37. Registrar's Signature

29b. Signature and title of certifier

Memorial Hospital, MD

29d. Date signed (Month, Day, Year)

March 11,2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 19a, per Fh G889 3/17/09 TT State of Maryland / Department of Health and Mental Hygiene. 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Joann T. Marquard 3-14-09 4:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Dundalk 3419 Liberty Parkway 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Hours Min. Months Days 1 ☐ M 2 🛛 F 71 5-26-1937 Director PA 216-34-0508 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10h County 10c City Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at 1 XYes 2 No Director MD Baltimore Dundalk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 3419 Liberty Parkway Funeral 21222 USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐XNo Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No Specify þ 3 Widowed 4 Divorced White "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Transportation School Bus Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael John Kentula မ Helen Theresa Petrunak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once. Tolston Daughter 3419 Liberty Parkway, Dundalk, MD 21222

Disposition (Name of Date 20c. Location - City or Town, State Theresa M. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 3-17-09 | Middle River, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bradley-Ashton Funeral Home PA, 2134 Willow Spring Road 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each 1, e. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 □Yes 2 ☑No Month Day Year 5 ☐ Other (specify) signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b irector, page 2 sl autopsy 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. n 24 hours after death.

The Funeral Director: A pletely filled in by the filled in th 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide 29a. Certifier 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 24 ho

To the Fune

completely f (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MU

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

09-02132 Janet Marsh Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

anet Marsh			ate of Maryl	and / Dep		Health			Hyg	iene	Reg. No	20	09	0828	
Physician ledical Examine	7 1	. Decedent's Name (First, Middl	_{e,Last)} Janet L.	. Mars					1	Date of De Month March 16	Day 5, 2 00	9	05	ne of Death 38 hrs	
	4	la. Facility Name (if not institutio 802 George Avenue	n, give street and n	umber)		b. City, Tov Essex	wn, or Lo	ocation of I	Death	v.,		c. County of D Baltimore			
Funeral Director	5	216-72-9506	6. Sex	7. Age (In yrs.		If Under Months		If Under 2 Hours	Min.	June		1958	J. Birthplace oreign Country)	(State or MD	
Maryland 28a-f show any d at once.		Usual Residence of Decedent 10a. State 10b. County 10b. Ba	ltimore	10c. Cit	y, Town or Locati Essex	on								nside City Limits Yes 2 X No	
th the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number 802 Georg	e Avenu	е		10f. Zip C		221			10g. Ci	itizen of What USA	Country?		
er death wi	-nue		Divorced If Yes, Give Year or Dates:			Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 X No specify: Ident's Usual Occupation (Give kind of work done						14. Race - A White, e Specify: . Kind of Busin	whit	e	
2 hour "naft	mpieted	Elementary/Secondary (0-12)	ost of worki	ng life. C	OO NOT us	e retired) .	c	CACI I	ACI Internationa					
1214 be fill mtal F	å	17. Father's Name (First, Middle James Ba 19a. Informant's Name/Relations	11 hip (Type, Print)	1 2	19b. Mailing	18.Mother's Name (First, Middle, Maiden Surname) Louise DeGaris Mailing Address (Street and Number or Rural Route Number; City or Town, State, Zip Code) D2 George Avenue Baltimore MD 21221								ode)	
nore, MD ages I and 2 sh nt of Health and :: If item 27 is other traumat		Ronald A. M 20a. Method of Disposition 1 Burial 2 X Cremation	3 Removal	20b	. Place of Dispos crematory or otl ayview	ition (Name	of ceme	etery,		Date	200	ore MD Location-Ci Baltim	ty or Town,	State	
Baltimore, permit. Pages I ar Department of He Important: If ite injury or other tr	1	4 Donation 5 Other States of Funeral Service G. G. Donation 5 Other States of Funeral Service 23a. Part I. Enter the disease, or	Licenses	ng		lame and A		-				Ave. of Es			
Physician /Medical xaminer	1	23a. Part I. Enter the disease, of failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. a. Cardi	V Lomegaly		ivent	ricu		5				Bet	roximate Interval ween Onset and Death	
led Insit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence							77				
0, be executed sician and purial - transit	edical	X UNPENDED	AMENDED	[I,27,pe	rME,	g889	3/3	1/09	TT						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the but	past 12 months? 4 Pregnant at time of death 5 Other (Specify)									Day	Year				
P.O. B res that the d signed by the be detached		Part II. Other significant condi Chronic obs					ause giv	en in Part	1.		tobacc	No 3		use of death? 4 Unknown	
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tal Rec	a B B	25. Was case referred to medica examiner?	Hospital:				10	of Death (Cother							
ion of Virending Physicath. or: After this the funeral dir	의	1 ✓ Yes 2 No 27. Manner of Death 1 X Natural 5 Pen 2 Accident Inve	28a. Dat (Mon	Inpatient 2 e of Injury hth, Day, Year)	ER/Outpatient 28b. Time of	Injury 28	Bc. Injury	at Work?	2	Home 5		dence 6 🗸		le .	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Cou 4 Homicide dete	ld not be rmined 28e. Pla	y)	home, farm, stre					or Town	, State)			ute Number, City	
To the Hos within 24 h To the Fur completely	edica	(Check only Certifying F	miner: On the basis and manner	s of examination	euge, death occu n and/or investiga	tion, in my	ppinion, License	death occu	e, and di urred at t	he time, da	te and p	se(s) and manner as stated. and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)			
		anesz	ubo ocasilara	upp of death in	om 22c\		O,C.N	1.E.			M	arch 16, 20	009		
			sistant Medical	Examiner	111 Penn S	Street, Ba	altimor	e, MD 2	21201						
Sta Registr	~	31. Date filed (Month, Day, Year)	7 2009 32.1	Registrar's Signa	ature .	arked	,							· - · · · · · · · · · · · · · · · · · · ·	

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Ye ar McMullen narch Arthur 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Season's Hospice Baltimore Randallstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Days Months Hours 215-40-7483 1**⊠** M 2∏ F 67 Yrs 9/11/1941 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 XYes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 430 South Gilmore Street 21223 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status uknown Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married White If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) uknown Pipe Fitter City Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) McMullen Louis н. Alice A. Dashkensch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stein / Caretaker 434 South Gilmore Street, Baltimore, MD21223 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory 3/16/2009 Hanover, MD 21. Signature of Funeral Service Licensee Porota Marshall 22. Name and Address of Facility
Maryland cremation Services <u>Po Box 1413, Baltimore, MD 21203</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Chronic Obstructive Pulmonary Stage disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last 130USO Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was *a*n 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother Specify HOSPICE 1∐ Yes 2XINo 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work?

Physician /Medical Examiner Examiner The law requires that the death certificate be executed

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

Be

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Funeral

Director

28a-f show

is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at

within 72 hours after

Pages 1 and 2 should be filed withinent of Health and Mental Hygiene.

If Item 27 i

permit. Page Department o Important: If any Injury or

Injury or other

Baltimore, Maryland 21215-0036

and I-transit g physician and sthe burial-tr attending p for use as t s been signed by the should be detached has page 2 s certificate this c I dire death. within 24 hours after death

To the Funeral Director:
completely filled in by the

Physician/Medical

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Completed

Be

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Certification:

Medical

State Registrar

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

To the

in the past 12 months? I∏Yes 2 No 9 Unknown

28d. Describe how injury occurred

1 Natural 5 Pending 2 Accident 3 🔲 Suicide

investigation 6 ☐ Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Iniun

1 ☐ Yes 2 🗌 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

29a. Certifier

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifie

NOTIVE

31. Date filed (Month, Day, Year) 2835 Smith

Registrar

State

5:58 A.M.

2009

TOHANNA

32. Registrar's Signature Denve B. park

2300 DULANEY VALLEY ROAD

TIMONIUM, MD

21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDDIE NAKHUDA, M.D.

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 15, 2009 Year MARCH **Physician** 5:55 P.M LOUIS F. MACHACEK /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner STELLA MARIS HOSPICE TIMONIUM BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1**X** M 2 □ F Months Days Hours Min. 219-18-2958 Director 87 8/23/1921 MARYLAND Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene. Important: yor Items 23a or 28a-f show important: If item 27 is marked other than "natural", or Items 23a or 28a-f show yor highly or other traumatic event, the Medical Examinar must be notified at once. 1 ☐ Yes 2 ☐ Xlo Director MD BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 MARYLAND AVENUE Funeral 21286 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? ▼Yes 2 No Race - American Indian. 11. Marital Status Black, White, etc. ty Tyes 2 □ No If Yes, Give Year or Dates: WWII filed within 72 hours after 1 Never Married 2 X Married 21215-0036 1 ☐ Yes 2 No Specify: Completed by WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) OWN BUSINESS YEARS MUSICIAN Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be h and Mental LOUIS M. MACHACEK ANITA SMRCINA ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TOWSON, ELIZABETH V. MACHACEK/WIFE 201 MARYLAND AVENUE MD 21286 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place MOST HOLY REDEEMER Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ó 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/19/2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Ucensee MO 1139 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) ☐Yes 2☐No P.O. signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 No 1 □ Yes 2X No of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 X Natural 1 🗆 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical X Nurse Practitioner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SR. DOROTHEA MAHOLLAND, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State Registrar

LOUIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** TM 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 X M 2 □ F 199-24-8176 78 Director Sept. 15, 1930 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show or than "natural", or items 23a or 28a-f show 1 ☐ Yes 2x No Director Catonsville Maryland | Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 719 Maiden Choice Lane Apt BR616 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 內 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Engineer Military Contractor nd 2 should be filed watth and Mental Hygier 27 is marked other the traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Beulah R. Rothenberger James A. Mease 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any injury or other traur 719 Maiden Choice Lane BR616; Catonsville, MD 21228 Helen Mease Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ₺ Burial 2 □ Cremation 3 □ Removal from State Laureldale Cemetery 3/18/2009 4 ☐ Donation 5 ☐ Other (Specify) Reading, Pennsylvania 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sdays Physician disease or condition resulting in death) wardenic /Medical Due to or a a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner burial-transi and resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the buria The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) signed by the a □Yes 2□No Ö 9 Unknown σ, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 □Yes 2 ONO To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 111 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 1 ☐ Natural 2 ☐ Accident 5 Pending investigation 1 🗆 Yes 2 🗆 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 13. 2009 7:10a March McClelland Ruth Leonora 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore <u>Charlestown Care</u> Center Catonsville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 27, 1928 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2√□ F 80 Yrs 216-24-7066 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No **Baltimore** Catonsville Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 USA 707 Maiden Choice Ln, Apt 7209 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐Yes 2 X No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) B&O Railroad Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Schuhart Edith Logan Charles 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernard A. McClelland (HUsband) 707 Maiden Choice Ln., Apt 7209, Catonsville 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 3/16/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part4: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Vallar disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

attending physician and for use as the burial-transit

ate has been signed by the apage 2 should be detached

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The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

or Attending Physician:

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To the Hospital within 24 hours a To the Funeral C Hospital

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The marked out of the than "natural", or items 23a or 28a-f show traumatic event, It a Modest Exprise natural to notified a

permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturous any injury or other traumatic power.

Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

autopsy performed 1 ☐ Yes 2, No 26. Place of Death (Check only one) Other: All Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Yes

28d. Describe how injury occurred

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner? 1 Yes 2 No

27 Manner of Death Natural 2 Accident

5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year) 28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier MD 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) gide

31. Date filed Wonth Year)

Registrar

State

Physician /Medical Examiner

Physician

/Medical

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Director

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Certification: To

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanture.

attending physician and for use as the burial-transi signed by the atte page 2 should peen has certificate this

Division of Vital Records, P.O. Box 68760,

Physician: The law requires that the death certificate be

or Attending

within 24 hours after death

To the Funeral Director:
completely filled in by the i

within 24 hours a To the Funeral L Hospital

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outco 1 ☐ Live bi 4 ☐ Pregna 9 ☐ Unkno
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2 □No 1 □ Yes 2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

29a. Certifier (Check only one) One) Certifying Physician: To the best of my knowledge, death occ of the death occ of the properties of examination and/or investigated.		
29b. Signature and title of certifier	29c, License number	29d. Date signed (Month, Day, Year
	0 110	A =

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

		_ POI	of Maryland /	Department of H		lental Hy	giene n	19 18293
	_	State Registrar		Certificate of	Death		Reg. No.	0) 00290
Physicia	an	1. Decedent's Name (First, Middle, Last)	11 1.			Date of De Month	ath Day	3. Time of Death
/Medic		Melvin	Mack	1	L. Carat Danie	March	912	2009 10:35PM
Examin	er	4a. Facility Name (If not institution, give street and no	umber)	4b. City, Town, o	r Location of Death		4c. County	of Death
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b	irthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th , ,	9. Birthplace (State or Foreign
Director		218-60-4721 1 X 2 F	56	Yrs. Months Days	Hours Min.	(Month, Da		Country) SC
pu		Usual Residence of Decedent	10 - City T-					10d. Inside City Limits
arylar shov	'n	10a. State 10b. County MD NA		wn or Location 1timore				1 Mary 2 □ No
the M	ect	10e. Street and Number		10f. Zip Code			10a Citizen of V	
urs after death with the Marylan al", or items 23a or 28a-f show Exanimer mettle	Funeral Director	2400 Winchester Str	eet Apt		1216		10g. Citizen of V	S.A.
ms 2%	nera		cedent Ever in U.S.	13. Was Decedent of H	lispanic Origin? (Spe	ecify Yes or No	- 14. Rac	e - American Indian,
after or ite	F	Armed F 1 XNever Married 2 Married 1 yes If Yes, G	2 🔽 No	1 □Yes 2X No	Specify:	rican, etc.)		k, White, etc.
ural",	d by	3 ☐ Widowed 4 ☐ Divorced Year or I	Dates:		, ,		Specify	
n 72 l	olete	15. Decedent's Education (Specify only highest grade completed)	 Decedent's Usual Occup (Give kind of work done life, DO NOT use retire) 	during most of worki	ng	16b. Kind of Bu	usiness/Industry
withi jiene. r thar	Completed	Sth grade College na	1-4or 5+)	Supervis	,		Chemic	al Plant
other vent,	Be C	17. Father's Name (First, Middle, Last)	,		18. Mother's Name		Maiden Surnam	e)
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Modical Evantian in the could be a compared to the Modical Evantian to a could be a compared to the Modical Evantian to a could be a compared to the Modical Evantian to a could be a considered to the Modical Evantian to a constitute of the Modical Evantian to a constitute of the Modical Evantian to	2	Calvin Mack			Anna Wi			
permit. Pages 1 and 2 should be filed within 72 hours afti Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, In IM dign Eva in once.		19a. Informant's Name/Relationship (Type. Print) Gwendolyn Jones-Sist	19 6	b. Mailing Address (Street	and Number or Rura	Balti	er, City or Town,	State, Zip Code) Md 21239
1 and Health em 27 ther tr		20a. Method of Disposition				Date		City or Town, State
Pages nent of int: If its iry or o		1 Burial 2 ☐ Cremation 3 ☐ Removal from		of Disposition (Name of ery, crematory or other place Memorial P				lawn, Md
artme ortan injur		4 Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee	1/)	22 Name and Addre		7,05	mood.	
permit. Departi		Musing B:	Ne ke	4300 Wab	ash Ave	, Balt	imore,	Md 21215
		23a. Part 1. Enter the disease, or complications that shock, or heart a ure. List only one cause on	caused the death. Do	not enter the mode of dyir	ng, such as cardiac o	or respiratory a	rrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	profound	,		٠		Onset and Death
/Medical Examiner		resulting in death)	(or as a consequence					7 3
LXaiiiiiei	-	Sequentially list conditions, b. — Due to	(or as a consequence	2.00:				
uted i nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	(or as a consequence	3 01).				
execun and ial-tra	Exa	resulting in death) Last C. Due to	(or as a consequence	e of):				To the other size
ficate be executed physician and s the burial-transit	dical	d						
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eath certifications attending properties as	lan/	23b. Was decedent pregnant in the past 12 months?	itcome of pregnancy birth 2 ☐ Fetal deat		:y		23d. Dat	e of delivery nth Day Year
The law requires that the death certifi ate has been signed by the attending bage 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Prei 9 ☐ Unknown 9 ☐ Unk	gnent et time of death nown	5 ☐ Other (specify) _		_	IVIO	nui bay real
that th	P.	Part II. Other significant conditions contributing to	death but not resulting	in the underlying cause giv	en in Part I.	23e. Did to	obacco use conti	ribute to the cause of death?
quires n sign lld be	d by	metabolic acy	105.5			1 🗆 1	Yes 2 □ No	3 ☐ Probably 4 ☐ Onknown
sw requir s been s s should	Completed		V • • • • • • • • • • • • • • • • • • •			24a. Was		Were autopsy findings available
The law ste has	шо					autor perfo 1 □ Yes	rmed?	orior to completion of cause of death? I □Yes 2 ☑Mo
sician: The la certificate ha rector, page 2	Bec	25. Was case referred to medical examiner?			26. Place of Death			1 1 1 2 2 2 1 1 0
hysic this ce		1 Yes 2 ☑ No Hospital: 1 □		Outpatient 3 DOA Oth	er: 4 Nursing Ho	me 5 🗆 Resid	dence 6 □Oth	er (Specify)
Attending Physician: ir death. ector: After this certific. by the funeral director, if	ion:	TENTALLIA S LI CHAING	e of Injury oth, Day, Year) 28b.	Time of Injury 28c. Injury Wor	Ŕ?	28d. Describe I	now injury occurr	ed
death death stor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be 28e Place	e of Injury - At home f	farm, street, factory, office	Yes 2□No	28f Location (Street and Numb	er or Rural Route Number,
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ospita hours ineral ly fille		29a. Certifier (Check only 2 Medical Examiner: On the	e best of my knowledg	ge, death occurred at the ti	me, date and place,	and due to the	cause(s) and ma	anner as stated.
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Medical		nner stated.	mwor investigation, in my (phillon, death occurr	eu at the time,	uale and place,	and que to the cause(s)
Veith veith	Σ	29b. Signature and title of certifier	6	29c. Licens	e number		29d. Date signed	(Month, Day, Year)
		Maria Cat,	W)	1000	23 6246	>	March	912 2009
t /		30. Name and address of person who completed cau	ise of death (Item 23a)) (Type, Print)), sh: = =	4	70 - 16	m.O => .
Stat	te	31. Date filed (Month, Day, Year) 32	Registrar's Signature	W DOCO W. B	anymor ?	reer,	TXXX Im ore	1100125/
Registra	ar	29b. Signature and title of certifier Manua Cat M 30. Name and address of person who completed cat Marcia Cort, mb Bon Sep 31. Date filed (Month, Day, Year) 32	we B.	park				

			For State	State of	Maryland		artment of I rtificate of		nd Men			009	08294
			Registrar 1. Decedent's Name (First, Middle, L.	ast)			- Inicate of	Death		ate of Death			3. Time of Death
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	Examin		4a. Facility Name (If not institution, gi		per)		4b. City, Town, o		Death		4c. Cou	nty of Death	IODE
or.			25 SADDLE COUR 5. Social Security Number 6.		. Age (In yrs. la	st hirthday)	BAL If Under 1 Year	TIMORE	Hrs. 8 r	ate of Rirth		BALTIM 9. Birthp	IUKE lace (State or Foreign
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	ъ		Usual Residence of Decedent 10a. State 10b. County		40- City	Town or Lo	agtion					14	Od. Inside City Limits
	/aryla	ō	MD BALTI	MUDE	Toc. City,		ALTIMORE						1 □Yes 2 No
	r 28a-	Director	10e. Street and Number	MONL		Dr.	10f. Zip Code			10	g. Citizen	of What Coun	try?
	th with	al D	25 SADDLE COURT				212	80				USA	
	tems	Funeral	11. Marital Status	12. Was Deced	es?	. 13.	Was Decedent of If Yes, specify Cub	Hispanic Orlgin an, Mexican, F	n? (Specify Puerto Ricar	Yes or No- n, etc.)		Race - Americ Black, White, e	
200	Irs afte	by F	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 If Yes, Give Year or Date			1 □Yes 2 🛣 No	Specify:			Spe	cify: W	HITE
5	72 hou	eted	15. Decedent's E (Specify only highest g	Education		16a. Dece	dent's Usual Occu	pation	f working	10	6b. Kind of	Business/Inc	lustry
7	vithin and the substitution of the substitutio	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	kind of work done DO NOT use retire ATTORNEY				LA	W	
7	filed v Hygie other t		17. Father's Name (First, Middle, Las				ATTORNET		Name (Fir	st, Middle, Ma			<u>.</u>
<u> </u>	ould be filed within Mental Hygiene. arked other than atic event, the Mental Hygiene.	To Be	HARRY		MILLER			MILD	RED		K	OENIGS	BERG
<u>a</u> 5	2 should be filed within 72 hours after death with the Maryland a and Memtal Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, it a Medical Examinar must be retified at		19a. Informant's Name/Relationship				ng Address (Stree				-		Code)
≥ ับ	Tand 2 shou Health and N tem 27 Is ma other trauma		JOAN MILLER / 20a. Method of Disposition	WIFE	20h Pla		SADDLE C		BALTIN Date			08 on - City or To	wn State
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If time Z1 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinar must be retified at once.		1 Maurial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		ate HEB		sition (Name of natory or other pla RIENDSHIP		3/15/2			IMORE,	
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			23a. Part 1. Enter the disease, or conshock, or heart failure. List onl	nplications that cau y one cause on eac	used the death. ch line.	Do not en			ardiac or res	spiratory arres	st,		Approximate Interval Between Onset and Death
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and the	Examiner			Due to (o.	r as a conseque	ence or):							
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h	xecute and II-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	r as a conseque	ence of):							
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Š	Physician: The law requires that the death certific this certificate has been signed by the attending praidirector, page 2 should be detached for use as	sician/Me	23b. Was decedent pregnant in the past 12 months?		rth 2 🗆 Fetal	death 3[Ectopic pregnan	су				Date of delive Month	ery Day Year
	the de	ysic	1 □Yes 2 □No 9 □ Unknown	9 Unknow	ant at time of de wn	ain 5L	Other (specify)						
Ĺ	s that gned b e deta	by Phys	Part II. Other significant conditions	contributing to dea	th but not resul	ting in the u	nderlying cause gi	ven in Part I.		23e. Did toba	acco use c	ontribute to th	ne cause of death?
ğ	equire sen siç ould b									1 ☐ Yes	No	o 3 ☐ Prob	ably 4 Unknown
Records	e 2 sh	ompleted						-	_	24a. Was an autopsy		b. Were auto prior to con death?	psy findings available mpletion of cause of
VICAL	ysician: The law requires that the de is certificate has been signed by the director, page 2 should be detached	e Co	25. Was case referred to medical	_				00 Bl			≥ No	1 ☐ Yes	2 🗆 No
	ysicla is cert directo	To Be	examiner?	Hospital: 1 ☐ In	patient 2 ☐ E	ER/Outpatie	nt 3 DOA Ot	hor		neck only one		Other (Specif	y)
5	ng ffe	on: T	27. Manner of Death 12 Natural 5 ☐ Pending	28a. Date of (Month	Injury , Day, Year)	28b. Time o Injury	Wo			Describe hov	v injury occ	curred	
IVISION	Attending or death. ector: Affel by the fune	icati	2 Accident investigati 3 Suicide 6 Could not	he .	of Injury . At hor	me form et	M 1 E]Yes 2 □ No	-	Location (Ctm	oot and Nu	mbor or Pura	I Route Number,
$\frac{1}{2}$	after of Direct of in by	Certification:	4 ☐ Homicide determine	d 200. Place of building	g, etc. (Specify))	eet, factory, office			City or Town,		mber or nura	i noute ivaniper,
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4	the H hin 24 the Fi	Medical	one)	and manne	er stated.		200 Licon	so number		20	d Data sid	anod (Month	Day Vaari
	§ 2 ₹ 2		29b. Signature and title of certifier	2161			250. Licer	2 (8 <	3 ~	29	7 2 /	il L	200 G
,		-	SQ. Name and address of person wh	o completed cause	of death (Item	23a) (Type,	Print)	100	ノリ		-	171	200/
		(90. Name and address of person wh 31. Date filed (Month, Day, Year)	lle,57	2 u	06	565 NORA	u CUM	Les s	Trees	5	retinos	re MISHYLDSA
	Sta Registr		31. Date filed (Month, Day, Year)	32. Re	gistrar's Signati	and the same							den (de
	negioti	- Til	MAK I (2003	Letter	- 1- 1								

State Registrar

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Ana Rubio MD.

29d. Date signed (Month, Day, Year)

March 14, 2009

29c. License number

O.C.M.E.

111 Penn Street, Baltimpre, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. 20 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician McKinzie earsor 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner Battimore Seasons Kandallstown Hospice If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 M 2 □ F Months Days Director raima Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1 1 Yes 2 □ No **Funeral Director** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UST 5333 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐Yes 2 ☐No Completed by 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Ovara 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pearson Thomas ဥ 19b. Mailing Address (Street and Number or Rural Foute Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hearson Chartty 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Se vice Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one causer in each line. pproximate nterval Between Onset and Death dving, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of **Examiner** Se pentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, burial-trar Due to (or as a consequence of) physician the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) has been signed by the e 2 should be detached 9 Unknown 9 Unknown contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy certificate 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifie

30. Name and address of person

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

nVik

29d. Date signed Month, Day, Year,

		For State		aryland / Dep	delible Ink. Ensur artment of Health ar <i>rtificate of Death</i>	nd Mental Hyg	_	08297
		Registrar 1. Decedent's Name (First, Middle	(runcate of Death	2. Date of Death		3. Time of Death
Physicia /Medic		MARIA GOR	ETTI PALMISA	ANO	T	March	13, 2009	10:20 P.™
Examin	er	4a. Facility Name (If not institution			4b. City, Town, or Location of I	Death	4c. County of Deal	
		Maria Health 5. Social Security Number		e (In yrs. last birthday)	Baltimore If Under 1 Year If Under 24	Hrs. 8 Date of Birth	Baltimor 9. Birt	Ehplace (State or Foreign
Funeral Director		220-24-9082 Usual Residence of Decedent	1 M 2 X F	79 Yrs.		Min. 8. Date of Birth (Month, Day, Nov. 6,	1929 Mar	yland
and and		10a. State 10b. County		10c. City, Town or Lo	ocation			10d. Inside City Limits
Maryl f sho	ō	Maryland Balti	mo 100	Dol+imor	30			1 □Yes 2 📉 No
the 28a	Director	Maryland Balti 10e. Street and Number	liore	Baltimor	10f. Zip Code	10	Og. Citizen of What Co	Juntry?
3a ol	0 1	6401 N. Charle	s Stroot		21212		U.S.A	
death ms 2	Funeral	11. Marital Status	12. Was Decedent E	Ever in U.S. 13.	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, I	n? (Specify Yes or No-	14. Race - Ame	erican Indian,
after or ite	F.	1X Never Married 2 ☐ Marr	ied Armed Forces? 1 □Yes 2√7 N If Yes, Give	10	1 ☐ Yes 2 X No Specify:	ruerto nicari, etc.)	Black, White	e, etc.
ral",	d by	3 Widowed 4 Divorced	Year or Dates:		TE TES ZENO OPECHY.		Specify: Wh	nite
72 hc 'natu	etec	15. Deceden (Specify only highes	t's Education st grade completed)	(Give	dent's Usual Occupation kind of work done during most o		16b. Kind of Business/	Industry
vithin sne. :han	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	DO NOT use retired)		T. 3	• -
iled v Hygie Ither I	ပိ	17. Father's Name (First, Middle,	5+ year	S	Administrator	s Name (First, Middle, N	Educat	.10n
be f ental	Be c		,					
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	은	Theodore 19a. Informant's Name/Relations	Palmisano	19b. Maili	Agne ng Address (Street and Number			Zip Code)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be notified at once.		Sr. Patricia G			N. Charles Str			
s 1 and f Health item 27 other tu		20a. Method of Disposition	LIIKa, S.S.N.	20b. Place of Dispo	osition (Name of matory or other place)	Date 2	20c. Location - City or	Town, State
Pages nent of ant: If ite ary or o		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		17-11- Ma	od o Complete	3-17-09	Glen_Arm, N	fortil and
permit. F Departm Importal any injui		21. Signature of Funeral Service		VIII RIA.	2. Name and Address of Facility	317 09 10	TEII_ALIII, P	aryrand
permi Depa Impo any ir		y Joseph	Fellan	1 _ ع	2. Name and Address of Facility Mitchell—Wiedef 6500 York Road ter the mode of dying, such as ca	eld Funeral Baltimore	Home, Inc	21212
		23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that caused		ter the mode of dying, such as ca	ardiac or respiratory arre	est,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	U	nd Cane	8 —			Onset and Death
/Medical		resulting in death)	Due to (or as a	a consequence of):	V			1.00100
Examiner		Sequentially list conditions,	b					
p ##	Examiner	if any, leading to immediate	Due to (or as a	a consequence of):				
and trans	Kam	Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence of):				
te be executed ysician and e burial-transit	a E		Due to (or as a	a consequence oi).				
leath certificate attending physi I for use as the I	dic		d					
certif nding ise as	Physician/Medic	IF FEMALE:	23c. If yes, outcome of	of pregnancy			23d. Date of de	livery
eath atter	ciar	23b. Was decedent pregnant in the past 12 mooths?	1 ☐ Live birth 4 ☐ Pregnant at		☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
the d by the	ysi	1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown	9 🗆 Unknown					
uires that the de signed by the a d be detached f	by Pi	Part II. Other significant condition	ons contributing to death bu	ut not resulting in the u	ınderlying cause given in Part I.	23e. Did tob	oacco use contribute to	the cause of death?
quires an sig uld b						1 🗆 Ye	s 2 1 NO 3 P	robably 4 🗌 Unknown
aw requir is been s	Completed					24a. Was ar		topsy findings available
The law tte has page 2 s	E O					autops perform 1 □ Yes 2	ned? death?	completion of cause of
ian: rtifica stor, p	Be C	25. Was case referred to medical			26. Place o	of Death (Check only one		
hysic nis ce		examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatie	nt 3 DOA Other: 4 Nurs	sing Home 5 Reside	nce 6 Other (Spe	cify)
ng PI fter tl ineral	Certification: To	27. Manner of Death 1 Natural 5 □ Pendin	28a. Date of Injur (Month, Day	ry 28b. Time o y, Year) lnjury	Work?	28d. Describe ho	w injury occurred	
tendi eath. or: A	cati	2 Accident investig	gation		M 1 □Yes 2 □No			
or Att fter d irect n by	ıţ	4 ☐ Homicide determ	ined 28e. Place of Inju	ury - At home, farm, st c. (Specify)	reet, factory, office	28f. Location (Str City or Town	reet and Number or Ru , State)	ural Route Number,
urs al		CON CONTRACTOR AND	Bharles Talle back	-4 tdd	M			
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical			f examination and/or i	th occurred at the time, date and nvestigation, in my opinion, death			
To th To th comp	Me	29b. Signature and title of certifie	r		29c. License number	29	9d. Date signed (Mont	h, Day, Year)
\		1 from	Juny MD		n57169		Mary 6.7	9009
,		30. Name and address of person	who completed cause of de	eath (Item 23a) (Type	Print)	(min	100 0	
		Daniel L	eng, Mr 6=	701 N. (hade: St #5105	Towser.	ND C1500	(
Sta		31. Date filed (Month, Day, Year)	7 2009 32. Registra	ar's Signature	barker			
Registr	ar	MAK T	1 ZUUJ DENGA	~ h. /				

			1- State of Maryland / Dep State Amend Item 11 per fh, g889	artment of Health 03/20/09dhb rtificate of Death			ene g. No 2009	08299
	Physici	an	1. Decedent's Name (First, Middle, Last)		2.	Date of Death Month	Day Yea	
	/Media	cal	Jerome C. Phelan, Jr.	T		arch	14 2009	
	Examir	ier	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location	of Death		4c. County of De Baltimo	
	Funeval		48 Oakway Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Timonium If Under 1 Year If Under	r 24 Hrs. 8	Date of Birth		or e irthplace (State or Foreign
	Funeral Director		219-22-6706 1½ M 2 F 80 Yrs.	Months Days Hours	Min.	Date of Birth (Month, Day,) arch 28	, 1928 M	Sountry) (State of 7 Gregorial Sountry)
			Usual Residence of Decedent		I.R	al Cli Zo	, 1920 P	aryranu
	show	_	10a. State 10b. County 10c. City, Town or Lo	ocation				10d. Inside City Limits
	Ba-f	Director	Md. Baltimore Timonium					1 □ Yes 2 □ No
	a or 2	ä	10e. Street and Number 48 Oakway Road	10f. Zip Code 21093		100	g. Citizen of What C US	*
	eath is 23	Funeral			riging (Chapit	·Vaa as Na		
õ	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Medical Eventral must be rediffed at		Armed Forces? 1 Never Married 2 Married 1-78 2 No	Was Decedent of Hispanic Or If Yes, specify Cuban, Mexical 1 ☐ Yes 2 ☐ No Specify.	an, Puerto Ric	an, etc.)	14. Race - An Black, Wh	
2-0036	ural",	d by	3 1 Wildowed 4 Divorced Year or Dates:	A				hite
<u>င်</u>	"nat	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during mos DO NOT use retired)	st of working	16	6b. Kind of Busines	s/Industry
7	withii iene. t han	E G	Elementary/Secondary (0-12) College (1-4or 5+) 5+ Engin	,		,	Engineeri	ησ
0	be filed ntal Hyg ed other event, I	Be C	17. Father's Name (First, Middle, Last)		ner's Name (F		iden Surname)	6
lan	Alenta Alenta rked tic ev	To B	Jerome C. Phelan, Sr.	Mai	ry E. l	Dohmer		,
ar ₂	and hardis ma		19a. Informant's Name/Relationship (Type. Print) 19b. Maili	ng Address (Street and Numb	per or Rural R	oute Number, C	City or Town, State,	Zip Code)
e, ≅	and and n 27			akway Rd. Timo	onium,	Md. 210	093	
HOLE	ges 1 t of H If iter or oth		20a. Method of Disposition 1	osition (Name of matory or other place)	Date	20	c. Location - City o	r Town, State
	t. Paertmen rtant:		4 Donation 5 Other (Specify) Most Holy		3–18–09	9]	Baltimore	e, Md.
Dalt	permit. Pages 1 and 2 should be fi Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic even once.		1 K L X	2. Name and Address of Facility Ruck Towso	on Fune	eral Ho	me, Inc.	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as	s cardiac or re	Spiratory arrest	MO • - Z 1 ZU4 t,	Approximate Interval Between
4.	Physician	1	Immediate Cause (Final disease or condition	a disease				Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):					- 3 Men 1
	Examiner		Sequentially list conditions, if any leading 1, immediate. Due to (or as a consequence of):					
	ted isit	Examiner	if any health t. immediate cause. Enter Underlying Cause (Disease or injury					
	execu and al-trai	xar	that initiated events resulting in death) Last C					
00/00	eath certificate be executed attending physician and for use as the burial-transit	Sal						
0	tificat g phy as the	edical	u.					
200	th cer endin	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Tetonia mannana.			23d. Date of de	elivery
_ 	e deal	sicia	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐	Ctopic pregnancy Other (specify)			Month	Day Year
Ċ	at the	Phy	9 LI ORKNOWN					
ń	res th signed	ρ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I	l.			to the cause of death?
corus,	requi	Completed	Λ Λ4		— ļ	1 ∐ Yes	2. No 3 ☐ F	Probably 4 Unknown
ב	e law has t	n de	_ cerebrorascular disease			24a. Was an autopsy	prior to	utopsy findings available completion of cause of
<u>_</u>	n: Th icate r, pag	ပ္ပ				performer 1 □ Yes 2 ⊡	d? death? No 1 □ Ye	s 2□No
=	siciar certif recto	Be	25. Was case referred to medical examiner? Hospital:	Other		heck only one)		
5	Phys raldi	٦.	1 ☐ Yes 2 ☐ No	IL 3 LI DUA 4 LI NU			e 6 ☐ Other (Spe	ecify)
5	ding th. : Afte	tion	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident investigation	28c. Injury at Work? M 1 □ Yes 2 □		Describe how	injury occurred	
2	Atter	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str		28f.	Location (Stree	et and Number or Fi	tural Route Number.
5	salor safte	Certification:	4 ☐ Homicide determined building, etc. (Specify)			City or Town, S	State)	·
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deatl and manner stated.	n occurred at the time, date ar vestigation, in my opinion, dea	nd place, and ath occurred a	due to the causet the time, date	se(s) and manner a and place, and du	as stated. e to the cause(s)
	To the vithin To the comple	Med	29b. Signature and title of certifier	29c. License number		29d.	. Date signed (Mon	th, Day, Year)
	,,,,		> Tawrence I bake on	0 D00301	22		3-16-	09
7		ł	30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)				V
			Lanvence J. Snyder 7505 05		Tow	50m 1	rd. 2120	4
	Stat Registra	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1.41				
				TO A STATE OF THE				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Month **Physician** 6:20 ам Thomas Parker 2009 Lee Jr. Feb. 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Thomas More Nursing Home Hyattsville PG If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08-28-1949 Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 577-66-9482 59 Yrs Wash. DC Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If "Medical Examination as Invition at 1 □Yes X \ No Director DC Washington 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1465 Oak St. NW #B3 20010 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 XNo Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify SpecifyBlack ð 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Lee Parker Sr. Pansy Bowles ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shawntell Brown/ Daughter 1428 Brentwood Rd. NE Wash. DC 20018 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 3-11-09 Riverdale, MD Riverdale Pk Crem. 5 Other (Specify) 4 Donation 22. Name and Address of Facilit Ronald Taylor II FH nature of F neral Service Licensee 10583 Middleport Ln. White Plains, MD 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician woull cu disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and burial-trar law requires that the death certificate be exect Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the detached 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, ð 2 No 1 🗆 Yes 3 Probably 4 Unknown Completed page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Physician: The certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medica examiner? director, Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After or Attending Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital within 24 hours a cal 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hyak will i 1835 univanta KURUP 31. Date filed (Month, Day, Year, 32. Registrar's State 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Rawls Hnn 12:45AM 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Renaissance Gardens Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 5. Social Security Number 379–14–8698 Days Hours 83 1 □ M 2 X F APR 21. Michigan Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show notified at 1 ☐ Yes 2X No MD Baltimore Catonsville Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or edical Examiner must be r 709 Maiden Choice Lane 21228 **USA** Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 ☐ Divorced er than "natur , the Medical R 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Wilson John Nusbaum ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages I and Department of Health an Important: If item 27 is Kellee Dougherty/daughter 6040 Kennard Ct Eldersburg, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc. 3/16/09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Cremation Society of Maryland, 299 Frederick Rd Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring 10 23a. Part1. Enter the disease, or complications that ocused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final **Physician** Preumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause. Universe of flury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed burial-trait Due to (or as a consequence of): Box 68760, physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 ☐ Other (specify) P.0. signed by the a d be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 3 Probably 4 donknown Obstructive pulmonary 1 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Dementia autopsy performed' 2 NO certificate funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 TYes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospitat or Attendii within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Destritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

BEZ-Registrar's Signature

Alexen Bowlin, mo Dyy377

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deneen Bowlin,

Choice

7-11 Maiden
31. Date filed (Month, Day, Ye

Year)

riease	Type of Print in Bi	ack indelible ink.	Ensure All Copie	s Are Let
	State of Maryland	Department of He	ealth and Mental Hy	/aiene

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30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	F. N F. S	Me	29b. Signature and title of	ftifier	and manner	statec.			29c. Lic	ense nu	umber			29d. D	ate signe	d (Mon	th, Day, Year)
Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			1 Can	ale	eup?				0.	C.M.E	Ξ.			Marc	h 7, 20	09	
State 31. Date filed 100 p. 7 2009 2. Registrar's Sign fure factors.					tant Medic	al Examine	r 111			ltimor	re, MD	21201					
			31. Date filed	7°2009	9 Jen	Registrar's Sign	ure 4	bad									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1059 A Frank J. Rossi 03-11-2009 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Date of Birth (Month, Day) **Funeral** Months Days Hours Min. 219-28-4489 76 Director 02-24-1933 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2X No Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 714 Cedar Crest Ct 21040 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian, Black, White, etc. 1 MYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛛 No Specify: <u>გ</u> Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Material Expediter Beth. Steel Ship Yard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Antonio Rossi Filomena Gianina ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health a
Important: If item 27 is
any injury or other trai Mary C. Rossi (Wife) 714 Cedar Crest Ct. Edgewood, MD 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus 03-16-2009 Dundalk, MD 21. Signature of Funeral Service Licensee Schimunek Funeral Home of BelAir Much D. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resiliratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last oconacu Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Dav 5 Other (specify) 1 ☐Yes 2 ☐ No 9 🗆 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available 2 Certification: To

has or Attending

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28a-f show

or than "natural", or items 23a or 28a-f show the Medical Examiner must be pullified at

and Mental Hygiene.

is marked other

Physician

/Medical

Examiner

filled in by the funeral To the Hospital of within 24 hours a To the Funeral C

					performed? 1 □ Yes 2 No	death? 1 □Yes 2 □ No				
25. Was case referred to examiner?	medical		26. Place of Death (Check only one)							
1 Yes 2 No		Hospital: 1 ☐ Inpatient 2 🔯	ER/Outpatient 3 DO	Other: 4 \sum Nursing Ho	ome 5 Residence 6	Other (Specify)				
2 ☐ Accident	Pending investigation		28b. Time of 20 Injury M	8c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury or	ccurred				
3 ☐ Suicide 6 ☐ 4 ☐ Homicide	determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factory, y)	office	28f. Location (Street and N City or Town, State)	umber or Rural Route Number,				
29a. Certifier (Check only 2	Certifying Phy Medical Exam	nysician: To the best of my kno niper: On the basis of examina	wledge, death occurred attion and/or investigation,	at the time, date and place, in my opinion, death occur	and due to the cause(s) an	d manner as stated.				

29c. License number

29b. Signature and

Medical

State Registrar

of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

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DHMH 17 Rev 1/2001

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			1 - For State Registrar	State of Ivialylan	Certifica				Reg. No.	09	0830
•	Physici: /Medic	-	1. Decedent's Name (First, Middle, La	ens Richai	rdson			2. Date of De	Pay 24	Year 209	3. Time of Death 10: 50P
•	Examin		42 Pacility Name (If not institution, give Rolling Park			11.	nocation of Death		4c. Count	of Death	
	Funeral Director		917 40-068 O	ex 7. Age (In yrs. 96	/ast birthday) If Und Month	er 1 Year	Hours Min.	8. Date of Bir Month, Da Cct. 7		9. Birthp Coun	lace (State or Foreig
	Maryland -f show fled at	tor	Usual Residence of Decedent 10a. State 10b. County		y, Town or Location					1	0d. Inside City Limit 1∰Yes 2 □ N
	h with the 3a or 28a st be notil	Funeral Director	10e. Street and Number 6 Stre	et, Apt. 211		Zip Code	211		10g. Citizen of	What Coun	try?
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		cedent of His becify Cuban 2 No	panic Origin? (Sp., Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		ce - America ck, White, of	
0-61717	filed within 72 ho Hygiene. ther than "natur ent, the Medical I	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	completed) College (1-4or 5+)	- 1	sual Occupat vork done du use retired)	iring most of worl	king	Baltic		1 1
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, Mai	and 2 sho lealth and m 27 Is ma her traums		19a Informant's Name/Relationship (J. Laws Nicken	s, Sr. Brother	19b. Mailing Addre	40th (Apt.309	Balto	IM,	, 21211
	permit. Pages 1 Department of H Important: If ite any injury or ot once.		20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 Other (Special	Removal from State	remetery, crematory o	rother place	J 3.a	0.09	Balt	mor	e, MD
מם	permit. Depart Import any inj		21. Signature of Funeral Service Lice	. Greene	515	isalt	a Nat	ene Fi	بع (21	229)
	Physician /Medical		23a. Part1. Enter the sease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line. Due to (or as a consequence)	ia	ode of dying	, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Examiner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b							
,00,00	tificate be executed g physician and as the burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conseq	uence of):						
O. DOX 00	siclan: The law requires that the death certificat certificate has been signed by the attending phy rector, page 2 should be detached for use as the	ysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregni 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	al death 3 ☐ Ectopic					ate of delive	ry Day Year
ecords, r.	quires that t in signed by uld be detac	ed by Phys	Part II. Other significant conditions of Williams Fred		ulting in the underlying	g cause giver	n in Part I.	23e. Did t			e cause of death? ably 4 □Unknow
	: The law re cate has bee page 2 sho	Completed						24a. Was auto perfo 1∐ Yes		prior to cor death?	psy findings availab npletion of cause of 2 ☐ No
N II G	ding Physiclan: h. After this certifica funeral director, p	Be	25. Was case referred to finedical examiner?	Hospital:		Othor	26. Place of Dea				
5	S S	-: To	1 Yes 2 No 27. Manna of Death	28a. Date of Injury	ER/Outpatient 3 28b. Time of	28c. Injury Work	4 Mursing H	ome 5 Resi	dence 6 □Ot how injury occu		/)
NISIOII	To the Hospital or Attending Physiclan: within 24 hours after death. To the Funeral Director; After this certific completely filled in by the funeral director,	Certification:	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 290 Place of injuny At h	Injury M ome, farm, street, fact	1 □ Y	? ′es 2 □ No	28f. Location (Street and Num	ber or Rura	l Route Number,
5	ospital or hours afte uneral Dir		29a. Certifier 1 Certifying Pl	nysician: To the best of my knominer: On the basis of examina	owledge, death occurre			, and due to the	cause(s) and m		
	the H in 24 the F	Medical	one)	and manner stated.	_						
)	To You't	~	Thabelle The	gregor ho		D 13	657		29d. Date sign		
			29b. Signature and title of certifier The belle The 30. Name and address of person who The belle The belle The belle (Month, Day, Year)	completed cause of death (Iter	n 23a) (Type, Print) J. 40 K SY	reets 1	Balthur	einaz.	12-11		
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Louella A. Ritchie 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Hospital Center 5. Social Security Number 6. Sex 7. Age (In vis. last birth Baltimore Rosedale If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 25, 1928 Birthplace (State or Foreign Country) Days Hours Months 1 □ M 2 12 F 232-36-5303 80 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Baltimore Essex 1 ☐ Yes 2 TXNo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21221 1900 Grove Manor Drive USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify Specify: White 3 □ Vidowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lawerance Rigsby Esta Brady 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) KAthleen Ritchie /daughter 10 Clipper Road Balto. MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 3/17/09 Baltimore MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mace Home Ave. Balto, MD of Essex 21221 300 Connelly Funeral 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Due to (or as a consequence of): oronary Art Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 DEctopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical **Examiner**

burial-trar

attending physician

Physician

/Medical

Examiner

10a, State

MD

Funeral

Director

ms 23a or 28a-f show must be notified at

or items,

the Medical

injury or other traumatic event,

and Mental Hygiene. is marked other than

permit. Pages 1 and 2 Department of Health a Important: If item 27 is

Director

Funeral

Completed by

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Ritchie

Hospital or Attending Physician: The law requires that the death certificate be executed

After this

Director:

within 24 hours a

To the Funeral C

completely filled in by the

Medical

Division or Vital Records, P.O. Box 68760,

Examine Physician/Medical þ Be Completed Certification: To

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy perform

2 No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 5 ☐ Pending investigation Injury 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 29b. Signature and title of certifier

1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

RES 0000

29d. Date signed (Month, Day, Year) 09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000 Franklin Square Drive, Baltimore, MD 21237 Walid Manga 32. Registrar's Signature 31. Date filed (Month, Day, Year

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #5 per Inf G897 11/23/09 TT State of Maryland 7 Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** CLEVELAND ROSENBORO MACCH 13, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOSPITAL Cross ILVER SPRINGS MONTGOMERY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Days Hours Min. 100 Jays Hours Min. 10 5. Social Security Number - 66-3909 9. Birthplace (State or Foreign **Funeral** JONES CO., NC 1 M 2□ F 66 Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 shov any injury or other traumatic event, the Medical Examinar count by nothing at 1XYes 2 □ No Director SILVER SPRINGS MD 10g. Citizen of What Country? 10e. Street and Number 2090 USA EGE VIEW Drive Funeral Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 No Specify. þ BIACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOTEL WAITER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROSENBORO EMMA ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSENBORD altimore, 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 03-21-09 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Parker Funeral +~ MO1363 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final ACDIAC Arr Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last burial-transit Exami law requires that the death certificate be execu and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as the t IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Atter this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 ☐ Inpatient 2 区ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 3/16/09 D0061937 Kan L 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CANDACE L. WILDON, MD - 1500 FOREST GLEN RD, SILVER SPRING, MT

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 17

State Registrar

VALERIY 31. Date filed (Month, Day, Year)

3altimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1- State Amend PI line a-d, 25,27,28a-f. Per MFote 890 e 5/15/09 TT 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Dora Robinson March 14 2009 8:08 /Medical Α 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville If Under 24 Hrs. Shady Grove Adventist Montgomery
9. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days Min. Months 1 □ M 2 🔀 F 91 Director 579-18-1096 8/13/1917 North Carolina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marchall Eventing must be reserved. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 No Directo MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17911 Cottonwood Terrace 20877 U.S.A Funeral 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?
1 ☐Yes 2▼ No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes. Give Specify Specify: Black Completed by 3 X Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Property Manager Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown မှ Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Torres/ Daughter 17911 Cottonwood Terrace, Gaithersburg, MD 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town. State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 3/16/2009 | Hanover, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature Funeral Service Licent 50 (A) 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MONTHS Immediate Cause (Final **Physician** Ventricular Tachycardia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Servere Sepsis Days-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) TEO BY MEDICAL EXAMINER Physician; The law requires that the death certificate be executed burial-transit Gastric Tube Complication Wooks and Due to (or as a consequence of): Lo M Box 68760. physician Advanced Dementia the ERTIF attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 □Yes 2 No 9 Unknown þ s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pneumonia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Gangrene 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has N autopsy page ; performe Immobility this certificate Vital 1 □ Yes 1 ☐Yes 2 ☐ No director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 XYes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ₹ within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred **PEG tube dislodgement/** Attending Division 4 St Natural 5 ☐ Pending investigation 1 ☐Yes 2X No 2 Accident Fd 3/8/2009 unknown^M malpositioning 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Fural Pouts Number of Found: 9701 Veirs determined 4 Homicide 9 Dr. Rockville, MD Found: Nursing Home Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and aggress of person who completed cause of death (Item 23a) (Type, Print) D0065830 03 iU 2009 Jamie Morano M.D. 9901 Medical Center Dr. Rockville, MD 20850 . Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 17 2009 Registrar

Certificate of Death

Black

21239

21215

29d. Date signed (Month, Day, Year)

MARCH 6.2009

Approximate Interval Between Onset and Death

YEARS

Physician	
/Medical	
Examiner	

2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Redmond Sr. Samuel William 10 03 06 2009 10:07aM 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Towson Gilchrist Hospice Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, 6. Sex Year) Min. Months Days Hours 1**X** M 2 □ F 04 14 VA 86 231-12-4290 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 TyrYes 2 □ No

Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ns 23a or 28a-f show must be notified at Directo Completed by Funeral o, "natural", Be ပ္

27 is marked other er traumatic event, !! Department of Health ar Important: If item 27 is any injury or other trau

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

the Hospital or Attending Physiclan: The law requires that the death certificate be executed ᆲ Division of Vital Records, P.O. Box 68760. reral Director: / within 24 hours To the Funeral

Baltimore MD NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21239 1549 Woodbourne Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 🛣 No Specify: Specify: 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Anderson Chevrolet Auto Mechanice 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Redmond Frances Ann Hill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William S. Redmond Jr.-Son 1549 Woodbourne Ave, Baltimore, Md 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/12/09 Baltimore, Md 4 Donation 5 DOther (Specify) Cedar Hill of Funeral Service License March Fr H West 4300 Wabash Ave, Baltimore, Md aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that shock, or hear trailure. List only one cause on Immediate Cause (Final disease or condition resulting in death) ENDSTAGE RENAL DISEASE Due to (or as a conse v ence of): HYPERTENSION Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ATHEROSCLEROSIS resulting in death) Last Due to (or as a consequence of)

Examir Physician/Medical Š Completed Be Medical Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year			
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?			
DIABETES		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown			
DEMENTIA		24a. Was an autopsy performed? 1			
25. Was case referred to medical examiner?	26. Place of Death (Check only one)			
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	5 ☐ Residence 6 ♥ Other (Specify) HOSPICE			
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 \(\subseteq 28 \)	d. Describe how injury occurred			
3 ☐ Suicide 6 ☐ Could not to determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	hysician: To the best of my knowledge, death occurred at the time, date and place, an iminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.				

29c. License number

D64395

State Registrar 31. Date filed (Month, Day, Year) MAR 1 1 2009

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-01959 State of Maryland / Department of Health and Mental Hygiene Wavne Robinson 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 2145 hrs **Medical Examiner** March 8, 2009 WAYNE ANTHONY ROBINSON, II 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Johns Hopkins Hospital If Under 1 Year | If Under 24Hrs > 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Min Director Country)MD 1 X M 2 F Yrs FEB 26. 1987 218-13-7890 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10h County 1 X Yes 2 No 23a or 28a-f show notified at once. BALTIMORE the Maryland Directo 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 1922 WILKENS AVE with Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, items must be White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Armed Forces' death 1 X Never Married 2 Married Yes 2 X No -Yes 2 X No specify: Specify: BLACK imore, MD 21215-0036
Pages 1 and 2 should be filled within 72 hours after ment of Health and Mental Hygiene. Yes, Give Yes Widowed Divorced 3 4 it: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ AUTO MECHANIC Com 12TH 18.Mother's.Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SHERRY PRICE WAYNE A. ROBINSON, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ٥ 19a, Informant's Name/Relationship (Type, Print) 1922 WILKENS AVE., BALTIMORE, MD 21223 SHERRY MARSHALL/MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date ítimore, 1 X Burial 2 Cremation 3 Removal from State (ant: 03/14/2009 BALTIMORE, OAK LAWN Donation 5, Other Specify or. 21. Signature of Funeral ervice License 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. Usley 21231 2007-09 EASTERN AVE., BALTIMORE, MD Part I. Enter the see se, or complications the failure. List only one cause on each line. aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva 23a, Part I. Enter the Physician Between Onset and /Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical UNPENDED **AMENDED** attending physician or use as the burial The law requires that the death certificate be Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month 3 Ectopic pregnancy Day Year Fetal death past 12 months' Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown detached for 9 the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ģ 1 Yes 2 V No 3 Probably 4 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available peen prior to completion of cause of autopsy certificate has performed? death? Yes 2 No 1 🗸 Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifi 26.Place of Death (Check only one) 25. Was case referred to medical director, Division of Vital Be examiner? Other₄ Hospital: Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: ٩ 1 V Yes funeral 28a. Date of Injury (Month, Day, Year) Mar 8, 2009 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Subject shot 1 Natural 2021 hrs Yes 2 V No Pendina the 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 3401 East Baltimore Street, Baltimore, Md. determined (Specify) Sidewalk 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely cal To the l 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

the

30. Name and address of person who completed cause of death (tem 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. 31. Date filed (Month, Day Yes istrar's Signature 2009 nous

29b. Signature and title of certifie

and manner stated

OCME

29d. Date signed (Month, Day, Year)

March 9, 2009

29c. License number O.C.M.E.

State

Registra

Division or Vital Records, P.O. Box 68760

Registrar

State Registrar

29b. Signature and title of certifier

30. Name and address of person

31. Date filed (Month, Day, Year)

Ness

DHMH 17 Rev 1/2001

W.D

who completed cause of death (Item 23a) (Type, Print) 8601 Veterans

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

my suite Zou, millersville, on 2108

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 2009 330 avid 3 O /Medical a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltine Cit ex University w If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 6. Sex 1 M 2 □ F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year Yrs. 48 216-86-9700 June 1,1960 Pennsylvania Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 'natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Md Balto. Nottingham 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21236 26 Lona Court USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. nt: If item 27 Is marked other than "natural", or iten 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Specify: δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Univ. of Md. Balto. Co. Asst.Professor of Voice 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If item 27 Is marked o any injury or other traumatic eve June L. Echard James L. Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rev. Cherie L. Smith 26 Lona Court Nottingham, Md. 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 □Burial 2 □ Cremation 3 □ Removal from State Gardens of Faith 3-21-2009 4 ☐ Donation 5 ☐ Other (Specify) Balto. City, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 9705 Belair Rd. Nottingham, Md. 21236 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions if any leading to impose cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending PhysIclan: The law requires that the death certificate be executed ysician and e burial-trans Due to (or as a consequence of): Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy fo Month Day Year 5 ☐ Other (specify) Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy certificate 1 ☐ Yes 2 🗆 No 2 NNc 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 □ Yes 2 \square No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direc 4 🗌 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier

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Baltimore, Maryland 21215-0036

P.0.

Division of Vital Records.

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's

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		1 - State Registrar	State of Mai	-	Certificat					2009	08314
Physicia		1. Decedent's Name (First, Middle, La Karen Lynn Stamp	•					2. Date of De Month 03-12		Yea	3. Time of Death 10:50 A M
/Medical Examiner		4a. Facility Name (If not institution, give street and number) 126 Arthur Ave					r Location of Death			c. County of De	
Funeral Director	100	5. Social Security Number 6. S	Sex 7. Age (1	In yrs. last birtl		1 Year Days	_	8. Date of Bit (Month, Date of Bit (Month, Date of Bit (Month, Date of Bit (Month, Date of Bit (Month)	1971		hirthplace (State or Foreign Country) NY
Maryland -f show lied at	tor	Usual Residence of Decedent 10a. State 10b. County MD Ceci		Oc. City, Town	or Location Deposit						10d. Inside City Limits 1 □ Yes 2X No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Important: If tier 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	10e. Street and Number 126 Arthur Ave			10f. Zip	Code 2190			USA		
		11. Marital Status 1 □ Never Married 2ሺ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Even Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:		13. Was Dece If Yes, spe 1 ☐ Yes		lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.))- 	Black, Wi	nerican Indian, nite, etc. Vhite
within 72 ho ene. than "natur ne Medical I		15. Decedent's Elementary/Secondary (0-12)	ducation rade completed) College (1-4or 5+)		Decedent's Usu (Give kind of wo life. DO NOT u	rk done i se retired	durina most of wor	king		Kind of Busines	s/Industry
uld be filed Mental Hygid rked other riic event, th		17. Father's Name (First, Middle, Last Richard L. Ruggl		1			18. Mother's Nar		l , Maide	n Surname)	
1 and 2 sho Health and ? Im 27 is ma ther trauma		19a. Informant's Name/Relationship (Eric Stamps (Hu 20a. Method of Disposition	(Type. Print) sband)	12	6 Arthu	ır Av	and Number or Ru e Port		, MI		
nit. Pages artment of h ortant: If ite injury or or		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Qce	fy)		Disposition (Nai), crematory or odge Mem 22. Name ar	. Ga:	r. 03-	18-2009			•
Department of the second of th		23a. Part1. Enter the disease, or com shock, or heart failure. List only	v	ne death. Do n	Inc. 6	10 W	Sc L. MacPha	il Rd B	elA	neral Ho	ome of BelAi 21014 Approximate Interval Between Onset and Death
Physician /Medical Examiner	Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. META Due to (or as a c			AST	CAN	CFR			Oliset and Death
icate be executed physician and sthe burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b Due to (or as a c	•							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death	3 ☐ Ectopic p 5 ☐ Other (s _i		/			23d. Date of d Month	delivery Day Year
equires that en signed b	by	Part II. Other significant conditions	contributing to death but	not resulting in	the underlying o	ause giv	en in Part I.	23e. Did 1 □		/	to the cause of death? Probably 4 □Unknown
sician: The law re s certificate has be irector, page 2 sho	Completed							24a. Was auto perfo 1 Yes		prior to death	
Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Impatient	2 □ ER/Out	patient 3□ D0	Oth	er:	th (Check only ome 5 Res		6 DOthor (Cr	and the
ending Physath. or: After thin he funeral or	ation: To	27. Manuer of Death 1 Matural 5 Pending investigation		28b. T		28c. Injur Wor		28d. Describe			isony
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification	3 ☐ Suicide 6 ☐ Could not b determined	building, etc.	(Specify)				City or To	wn, Stat	te)	Rural Route Number,
the Hosp thin 24 hor the Fund ompletely f	Medical	(Check only 2 Medical Exa	hysician: To the best of iminer: On the basis of e and manner state	xamination and d.	f/or investigation	n, in my d	opinion, death occi	irred at the time	, date ar	nd place, and d	ue to the cause(s)
ř » ř ŏ		30. Name and address of person who	completed cause of dea	th (Item 23a) (1	Гуре, Prinţ)	D	166 A		m	arch	nth, Day, Year) 12, 2009 MD - 2123 J
\(\mathbb{l} \)	ite	C, VERGARA — SO. 31. Date filed (Month, Day, Year)	ARFC 9940 39. Registrar	D FRA	UKLIN	SQU	IARE I	DR. NOT	TING	SHAM,	MD 21236
Registr	ar	MAR 1 7 200	19 Sentina	B. A	Tarket						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Day Month 21:30M 200 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) Year) Months Days Hours 122 M 2□ F DČ JUNE 2, 1957 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 AYes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1. 4/3 Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No . Race - American Indian, Black White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐Yes 2X No Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) COMPUTER PROGRAMMER PRIVATE YR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CLIFTON BERNARD SLADE, SR. FAY TAYLOR 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) / FATHER 607 HARRISON CIRCLE LOCUST GROVE, VA CLIFTON B. SLADE, SR. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State INCOLN MEMORIAL CEM. 03-17-2009 SUITLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 21. Signature of Funeral Service Licensee DeSHAUN L. WATTS 20746 4308 SUITLAND ROAD SUITLAND, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 5161110 Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Director

Funeral

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Saltimore, Maryland 21215-0036

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

and Mental Hygiene.

If item 27 is

Department of Important: If it any injury or o once.

Physician/Medical Examiner physician and the burial-transit attending pl for use as t After this certificate has been signed by the funeral director, page 2 should be detached Certification: To ithin 24 hours after death.

The Funeral Director: After proper the function of the function o

To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed

Division of Vital Records, P.O.

Box 68760,

Completed by Be

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

1 Yes 2 No

27. Manner of Death

2 Accident

4 Homicide

3 ☐ Suicide

1 X Natural

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? Hospital:

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

26. Place of Death (Check only one)

24a. Was an perform 2 No

1 □Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24b. Were autopsy findings available prior to completion of cause of death?

2 No

29a, Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and the of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, 30

31. Date filed (Month, Day,

5 ☐ Pending investigation

6 ☐ Could not be

State Registrar

Medical

within 2 To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 200 ERIUN O MUN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard County General Hospital Howard Columbia 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 → M 2 □ F Months Days Hours 163-28-5106 73 Jan 01, 1936 PA **Director** Usual Residence of Decedent should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County r than "natural", or items 23a or 28a-f shoving Medical Exa., inc., ust be notified at Woodstock 1 TYes 2 □ No MD Howard Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11110 Chambers Court 21163 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 GYes 2 □ No Air If Yes, Give Year or Dates: Force Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black ģ Force 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Management Consultant Self-Employed traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marion Hugh Solomon Arra Cleo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charlotte M. Solomon/wife 11110 Chambers Court, Woodstock, MD 21163 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 3/19/2009 Owings Mills, MD ^{22. Name and Address of Facility}
Lewis N. Watson Funeral Home, PA
1618 West Road, Salisbury, MD 21801 21. Signature of Funeral Survive Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arkley thours **Physician** disease or condition /Medical resulting in death) Examiner 122260 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examine Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy Year Month Day 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 □No 1 ☐ Yes 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director After this completely filled in by the funeral dir 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

7 2009

32. Registra 's Signa

			State of Maryland / De State of Maryland / De State	epartment of F Certificate of		ntal Hygie _{Reg.}	2000	08317		
			1. Decedent's Name (First, Middle, Last)		2.	Date of Death Month	Day Year	3. Time of Death		
	Physicia /Medic		Joan E. Scott		1	Tarch.	05 2009	1:05 PM		
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Co							
	,		Manor Care, Ruxton 5. Social Security Number 6. Sex 7. Age (In yrs. last birth		OWSON If Under 24 Hrs. 8,	Date of Birth	Balti	more lace (State or Foreign		
	Funeral Director		215-30-4169 1□ M 2፟፟M F 74 Yr	Months Days	Hours Min.	Date of Birth (Month, Day, Ye)	1934 Mar	yland		
	pug w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	r Location			11	Od. Inside City Limits		
	/aryla	ō		1				1 □Yes 2 X No		
	the 28a	Director	MD Baltimore Coc	keysville 10f. Zip Code		10g.	Citizen of What Coun	try?		
	3a ol		16 C. Warren Lodge Ct.	210	30		USA			
	death	Funeral		13. Was Decedent of H	Hispanic Origin? (Specif an, Mexican, Puerto Ric	y Yes or No-	14. Race - Americ Black, White, e			
5-0036	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show saften Evandrac misal be notified at	by	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 □Yes 2XINo		,		ite		
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Maryland	lid be fental rked o		George Falkenhan		Joseph	ine	McGrail			
ar∠	shou and M s mai		19a. Informant's Name/Relationship (Type. Print) 19b. N	Mailing Address (Street	and Number or Rural F		ity or Town, State, Zip	Code)		
	and 2 salth a n 27 is			4 St. Paul		stead, M				
ore	jes 1 a		20a. Method of Disposition 20b. Place of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 30b. Place of Disposition	isposition (Name of crematory or other pla	ce) March	²⁰⁰	c. Location - City or To	wn, State		
altimore,	t. Pag rtment rtant:		4 □ Donation 5 □ Other (Specify)	oly Redeeme	, 2005		Baltimor			
g	permit. Pages 1 and 2 should be f Department of Health and Mental Important: If item 27 is marked or any injury or other traumatic eve once.	la j	21 Ignatur Fulleral Service License V Bryan W. Clary	Lemmon Fu 10 W. Pad	ess of Facility neral Home onia Road	of Dula Timoniu	ney Valley m, MD 2109	, Inc. 3		
ī			23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failule. List only one cause or each line.	t enter the mode of dyi				Approximate Interval Between		
To the same	Physician		Immediate C ise (Final disease or condition a. A cite Respiratory Failure (Aay)							
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US.	outed id ansit	Examiner	Sequentially list conditions, if any lead to introduce to cause. Enter Underlying Cause (Disease or injury that initiated events Due to [or as a consequence of]:							
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	siciar certif	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	otiont 2 DOA Oti	26. Place of Death (e 6 □Other (Specif			
o	ding Phys T. After this funeral di	7: To	27. Manner of Death 28a. Date of Injury 28b. Ti	ne of 28c, Inju		d. Describe how		y)		
<u></u>	nding ath. r: After e funer	aţio	1 Natural 5 □ Pending (Month, Day, Year) Inj 2 □ Accident investigation		rk?]Yes 2□No					
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farr building, etc. (Specify)	n, street, factory, office	281	f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,		
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in		29a. Certifier (Check only (C							
	To the I within 2 To the I complet	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. Licen	se number	29d.	. Date signed (Month,	Day, Year)		
	FSFÖ		Robled & Altendin	a Doc	59782	ħ	March r	n6 2009		
	4		30. Name and address of person who completed cause of death (Item 23a) (1	ype, Print)	,01400		11001011	, , , , , ,		
	1		Richard O. Addo MD 7100	North (harles &	treet,	Towson, 1	D 21204		
	Sta		30. Name and altirbss of person who completed cause of death (item 23a) (item	arks		1	(
	Registi	rar	Will T I PAGE MAIN							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08318 Reg. No.2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year Stase S. Surdokas 11:40PM MAR /Medical 2009 0 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITAL ST AGNES BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year, 07/25/1924 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours Min 1 □ M 2X F 84 Director Lithuania <u>215-</u>30-2243 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f show event, the Medical Evaminer must be notified at Director 1 ☐ Yes 2 X No Maryland Baltimore Catonsville filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 6244 Gilson Park Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②XNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕅 📉 o Specify. Specify: White ģ 3XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic evonce. Unknown Sakeviciute Stase Unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christel Surdokas - Daudhter-In-Law 5912 Cecil Avenue Baltimore, Maeryland 21207 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/16/2009 Baltimore, Maryland rature of Funeral Service Licensee 22. Name and Address of Facility
David J. Weber Funeral Homes P.A. 5311 Edmondson Avenue Baltimore, Maryland 21229 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shrick, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a. CLOSTRIDIUM DAYS DIFFICLE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of rsician and burial-transit Exami Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical SURDOKA IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) icate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 HYPOTENSION Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an this certificate performed Division of Vital 1 □Yes 2√□Mo funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) ne Hospital or Attending P in 24 hours after death.

P Funeral Director: After t pletely filled in by the funera 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the To the within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P23748 MD Max. 10, 2009

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

RAJANI JAGANA, ST AGNES HOSPITAL, 900 SOUTH CATON AVENUE, BALTIMORE, MD 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 12 per MD 1889 3/23/09 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 16 Day Year Month Scaffidi Joseph March 2009 4:35 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9 - 2 , 1 9 2 2 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1**⋈**M 2□F Days Hours Min. 216-32-6486 Maryland Usual Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 120 S. Highland Avenue 21224 12. Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XNever Married 2 ☐ Married 1 ☐ Yes 2 ੌ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Balto. City Dept. Elementary/Secondary (0-12) 6th College (1-4or 5+) Pipefitter of Works Public 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cono Scaffidi Rosa Spinella 19a. Informant's Name/Relationship (Type. Print)

Christina Wohlfort - Niece 5 Farm Ridge Ct. Baldwin, Md 21013 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Oaklawn Cemetery 3-19-2009 Balto. Maryland 4 □ Donation 5 XOther (Specify) Entomb 22. Name and Address of Facility Joseph N. Zannino Jr. 263 S. Conkling St. Balto. Md. 21224 21. Signature of Funeral Service Licensee 23a. Part T. Enter the disease, o shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive heart failure disease or condition (resulting in death) None week Due to for as a consequence of): Pneumonia, possibly community-acquired Due to (or as a consequence of): N 1 to 2 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Ischemic cardiomyopathy
Due to (or as a consequence of): 6 months Diabetes mellitus 26 months IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Advanced dementia, dysphagia, peripheral 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 25. Was case referred to medical examiner? 1 □ Yes 2 **N**o 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner Examiner law requires that the death certificate be executed

Physician

Examiner

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the involved at

Department of Health and Mental I mportant: If item 27 is marked of any injury or other traumatic eve

Maryland 21215-0036

Baltimore,

Box 68760,

P.0.

Division of Vital Records,

Hospital or Attending Physician: The

death.

within 24 hours after death To the Funeral Director: filled in by the

completely

Pages 1

/Medical

10a. State

MD

Director

Funeral

Completed

burial-trar physician the burial attending ph for use as the sate has been signed by the page 2 should be detached certificate : After this certifica e funeral director, r

Physician/Medical

Completed by

Be

Medical Certification: To

in the past 12 months? 1 □Yes 2 □ No 9 Unknown

vascular disease, chronic kidney disease

1 Yes 2 No 27. Manner of Death

5 Pending investigation

28a. Date of Injury (Month, Day, Year) 6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

2 Accident

3 Suicide

29a, Certifier

4 Homicide

29b. Signature and title of certifier Phetty. Dinaano, M.D. 29c. License number D0065809

March 16, 2009

Touson MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GBMC 6701 N. Charles St.

Rhett P. Dimacino, M.D. ad (Month, Day, Year) 32. Begistrar's Signature 31. Date filed (Month, Day, Year) MAR 17 2009

Registrar

4a. Facility Name (If not institution, give street and number)

Francis J. Sedlak, Sr.

1. Decedent's Name (First, Middle, Last)

Physician

/Medical

Examiner

Certificate of Death

4b. City, Town, or Location of Death

2. Date of Death Month

March

Dav

2009

4c. County of Death

Baltimore

6:25 a

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 ☐ No

New Jersey

USA

White

14. Race - American Indian Black, White, etc.

Specify:

23d. Date of delivery

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Day

24b. Were autopsy findings available prior to completion of cause of death?

2 No

State Registrar

completely

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

6 Could not be

determined

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registr

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

10 wsarton

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene per me, g890,04/09/09dhb Reg. No. Reg. No. 1- For Amend Item 25
Registrar 25 Reg. No. dent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 338 Month O3 Day **Physician** 2009 /Medical Facility Name (If 4b. City, Town or Location of Death not institution, give street and number) 4c. County of Death **Examiner** Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 Months Days Hours Min. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or items 23a or 28a-f show Examiner must be notified at BALTO nd 1 Nes 2 No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number PRATT ST. 21201 4-5A 833 W 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give' Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 4. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ₩idowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than "nature traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0.12) College (1-4or 5+) Home Hygiene. OME MAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, 19a. Informant's Name/Relationship (Type. Department of Health a Important; if item 27 is any injury or other tra once. AUA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ② Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CREMATOR1/3-10-09 HANOVER VIS SV. FUNERAL HOME 21, Signature of Funeral Service Licensee Wesley L AVR. 2007EASTERN 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as car liac or respiratory arrest, shock, or heart failure List only one cause on ach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due t ence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 20 No Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? eath but not resulting in the underlying cause given in Part I. Š 2 🗌 No 3 Probably 4 Unknown is certificate has been s director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy perform 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 Department 2 ER/Outpatient 3 DOA Medical Certification: To this After thi funeral of 27. Manner eath 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Litural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29d. Date signed (Month, Day, Year) License number 29b. Signature and title of certif State Registrar

Patricia Kaylene Smith

			1-For State Criticate of Death Registrar Certificate of Death	Reg.	No. 200	9 0832			
	Physici dical Exam			2. Date of Death		3. Time of Death			
viec	ılcal Exam	iner	PATRICIA KAYLENE SMITH	Month D March 6, 200		0738 hrs			
			4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 6707 German Hill Road Baltimore		4c. County of Deat	n .			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8. Date of Birth(MM/DD/YYYY) 9. Bi	rthplace (State or			
	Director		215-90-3269 1 M 2 X F 44 Yrs. Months Days Hours Min.	APR. 7,	1064 Forei	gn ountry) MD			
		ĺ	Usual Residence of Decedent	APR. /,	1904				
	w any		10a. State 10b. County 10c. City, Town or Location		, , ,, ,,	10d. Inside City Limits			
	Aaryland 28a-f show any 1 at once.	tor	MD BALTIMORE 10e. Street and Number 10f. Zin Code			1 X Yes 2 No			
	th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Cou	ntry?			
7	MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental HygienAmental Hygien 27 is marked other than "matural", or items 23a or 28a-f she prise ment, the Medical Examiner must be notified at once invatic event, the Medical Examiner.		6707 GFRMAN HTLL RD. 21222 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	scify Ves or No.	USA	ican Indian, Black,			
	leath v r item rust b	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No		White, etc.	ican indian, brack,			
	after d al", on ner m	by F	3 Widowed 4 Divorced of Yes 2 No 1 Yes 2 X No specify:	llia.	Specify: WH	ITE			
	hours natur		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of working life, DO NOT use retire		6b. Kind of Business	Industry			
	36 in 72 han " lical I	ompleted	College (1-4 or 5+)	, ,					
	d with	mo;	12TH HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (I	First Middle Mair	HOME				
	21215-0036 and be filed within 72 Mental Hygiene. marked other than 'c event, the Medical	Be C	CONLEY W. SMITH MARY ALI		acii dolliane)				
	21 nould I d Mer is mar	Tol	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru		r, City or Town, State	e, Zip Code)			
	MD and 2 sho alth and m 27 is aumat		MARTIN ZEMBOWER/FRIEND 6707 GERMAN HILL RD.,			21222			
	ore, of Hea of Hea If ite		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 2	0c. Location - City or	Town, State			
	Baltimore, bepartment of He Important: If ite		4 Donation 5 Other Specify: ARDENT 03/1	2/2009	HANOVER,	MD			
	Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Department of Health and Aental Hygene. Important: If item 27 is marked other I injury or other traumatic event, the Med		21. Signature of Funeral Service Licensee 22. Name and Address of Facility WESI						
	Physician		2007–09 EASTERN AV 23a. Part I. Enter the dispase, or complications that leaves the death. Do not enter the mode of dying, such as cardiac or r	E., BALT	Shock or heart	21231 Approximate Interval			
	/Medical	0 9	failure. List only of cause on each line.			Between Onset and Death			
	Examiner		Immediate Cause (Final disease or condition resulting in death) A Hypertensive atherosclerotic cardioval due to (or as a consequence of):	iscular (iisease	Dod.:			
		L	Sequentially list conditions, b						
		if any, leading to immediate Due to (or as a consequence of): Cause. Enter Underlying Cause (Disease or injury that initiated C.							
	sit d	Exan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
	xecuted n and - transit		X UNPENDED AMENDED 23a,27,perME, g889 3/20/09 TT						
	760, cate be ex physician he burial	Medical							
	3876 rtifical ing ph as the		23b. Was decedent pregnant in the	ľ	23d. Date of deliver	V Day Year			
	Box 687 death certific the attending	sici	past 12 months? 4 Pregnant at time of death 5 Other (Specify)						
	the de	Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	220 Did tohor	cco use contribute to	M			
	ires that the signed by the detache	ð	Continuous de la contin			pably 4 V Unknown			
	rds, require been si hould t	Completed		24a. Was an		topsy findings available			
	e law e has l ge 2 sh	ם		autopsy performed	prior to d	completion of cause of			
	Ital Recirian: The certificate		25. Was case referred to medical 26.Place of Death (Check on		No 1 ✓ Ye	es 2 No			
	of Vital Records, g Physician: The law require this certificate has been si neral director, page 2 should b	To Be	examiner? Hospital: JOther:		sidence 6 🗸 Other	: Scene			
	n of ing Ph After t uneral		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 2	8d. Describe how					
	Division tal or Attendii rs after death. al Director: A led in by the fu	Certification:	1 X Natural 5 Pending 2 Accident Investigation (World), Day, Tear) 1 Yes 2 No						
	Divis pital or At ours after d ceral Direc filled in by	#	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	8f. Location (Street or Town, State		ral Route Number, City			
	ospita hours Interal		4 Homicide determined (Specify) 29a. Certifier		<u> </u>				
	Division of Vital Records, P.O. Box 68760, with 12 the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only representation and or investigation, in my opinion, death occurred at the time, date and place, and due one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due one)	ue to the cause(s) he time, date and	and manner as state	ed. e cause(s)			
	To wit	Me	and manner stated. 29b. Signature and title of certifier 29c. License number		ld. Date signed (Moi				
•			Parter Var. Hay 11 mgs		larch 6, 2009	,,,			
		ŀ	30. Name and address of person who completed cause of death (Item 23a)						
_			Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201					
			31. Date filed (Month, Day, Year) MAR 1 7 2009 32. Registrar's Signature MAR 1 7 2009						
	Regist	ııcı	MAKI 1 2000 Denover 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND, ITEM#19a perFH G889 3/20/09 WS
State of Maryland 7 Benartinent of Health and Mental Hygiene
Amend #17 per FH G889 3/27/09 11 Cértificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** March 13 2009 7:57aM Phyllis Μ. Tracy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6604 Hampnett Avenue HAMILTON 9. Birthplace (State or Foreign Country)
1 9 4 9 MD 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex Funeral ^{Year)} Months 1 □ M 2 🔀 F Days Hours 216-52-3932 59 April Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be recilled at Director Hamilton 1 XYes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6604 Hampnett Avenue 21214 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 ☐**X**lo If Yes, Give Specify White Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Waitress Food 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mabel Ziegenhein William H. Barclay 19a. Informant's Name/Relationship (Type. Print)

Kathleen McConnell/Daught and 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6604 Hampnett Ave. Baltimore, MD 21214 s 1 and 2 of Health a item 27 is 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o ō Cremation 3 Removal from State Bayview Crematory03/14/09 Baltimore, MD 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Baltimore, Connelly Funeral Home of Essex 21221, 21. Signature of Funeral Service Ligensee umu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OBSTRUCTIVE PULMONARY DISCASE **Physician** CHRONIC /Medical Due to (or as a consequence of): Examiner 16AKUTE 8mo KING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed burial-transit Due to (or as a consequence of) Box 68760. physician Physician/Medical the attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 0 1 ☐ Yes 2 ☐ No the 9 Unknown signed by the 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ EDEMA 2 No 3 Probably 4 Unknown Completed CHRONIC COUTIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

1 Yes 2 No To the Hospital or Attending Physician: The this certificate 1 ☐ Yes 2 ☐ No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funeral Director;
completely filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SERGNA R. NOCAN NO. 8831 SAFYL HILL A 8831 SATYL HILL BO \$100 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 5:30 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Stella Maris Hospice Timonium Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | 10/27/1947 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months 1**X**M 2□ F 212-46-7021 61 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD **Baltimore** 1 XYes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1420 East Fort Avenue 21230 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 □Yes 2 No 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Sr. Caroline L. Lee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Caroline M. Thomas / Daughter 1420 East Fort Avenue, Baltimore, MD 21230 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Cedar Hill Cemetery ₩Burial 2 ☐ Cremation 3 ☐ Removal from State 3/16/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if only leading to the first cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Dav 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

Director

Funeral

Be

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r than "natural", or items 23a or 28a-f show the Medical Experimer must be notified at

death 1

filed within 72 hours after

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Pages 1 and 2 should I

and is

of Health in item 27 is other tra

Department of Important: If its any Injury or o

Saltimore, Maryland 21215-0036

attending physician and for use as the burial-transit The law requires that the death certificate be executed been signed by the should be detached certificate has birector, page 2 s director,

P.O.

Records,

Division of Vital

Physician/Medical 2 Completed Certification: To

Examiner 27. Manner of Death

25. Was case referred to medical

Medical

State Registrar

spital or Attending Physiours after death.
neral Director: After this y filled in by the funeral di

title of certifier

1 Yes 2 No

2 Accident

3 ☐ Suicide

29a. Certifier

29b. Signature a

4 ☐ Homicide



1000

28a. Date of Injury (Month, Day, Year)

and manner stated

Hospital:

5 Pending investigation

6 ☐Could not be

Chests

Registrar's Signatu

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

1 ☐ Yes 2 ☐ No 3 ☐ Probably A Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Yes No 1 □ Yes

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 XOther (Specify) Hospice

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

TCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Vally Ger Lother 1/2 21093

_			For State Registrar	State of Maryl		ertificate of		R	eg. No.	09	08326
	Physic	ian	1. Decedent's Name (First, Middle, La	•				Date of Dear Month	Day	Year	3. Time of Death
	/Medi	cal	John Edward T 4a. Facility Name (If not institution, give			4b City Town or	Location of Death	March	15 20 4c. County of	009	10:10 P ^M
	Exami	ner	Stella Maris Ho	·		Timon				imore	
	Funeral	Г	5. Social Security Number 6. S		yrs. last birthday		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	1		e (State or Foreign
	Director		213-12-0927	8 8	7 Yrs.	Montrio Buyo	Trodio Willia	December		Mary	
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation.				10d.	Inside City Limits
	Mary a-fsh	ctor	Maryland St Mar	vie Co	liforni	2					1 □Yes 2 🙀 No
	or 28	Dire	Maryland St. Mar 10e. Street and Number		11.11.7/1111	10f. Zip Code		1	0g. Citizen of W	,	?
	s 23a	ra	23264 Surrey Wa		110	20619			U.S		
	ter de ritem inerr	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces?	n U.S. 13	. Was Decedent of H If Yes, specify Cuba	nspanic Origin? (Span, Mexican, Puerto	Rican, etc.)		- American , White, etc.	
E 036	ral", o	þ	3 √ Widowed 4 □ Divorced	1 Dyes 2 □ No If Yes, Give 1942 Year or Dates:	2-1945	1 □Yes 2 🔯 No	Specify:		Specify:	Whi	te
0 1	72 hc	etec	15. Decedent's Education (Specify only highest grant programme)	ducation ade completed)	16a. Dec	edent's Usual Occup e kind of work done o DO NOT use retired	ation during most of work	ng I	16b. Kind of Bus	siness/Indus	try
10:10 p.m.	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show fry Modicel Examinat must be rediffed at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		inter	3)		Federal	Gover	rnment
	il Hygi other	Be Co	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, I			Tunerre
09 Vlar	should be and Mental s marked o	10 E	William Earne	st Tracey			Mary E	llen Wh	nitty		
2009 Maryland	2 sho and is ma		19a. Informant's Name/Relationship (Type. Print)		ling Address (Street			•	State, Zip Co	ode)
•	C 25 54 5		Thomas Ray Tracey 20a. Method of Disposition	/ Son		Harview			20c. Location - 0	1234	State
H 1	Pages nent of int: If its iry or o		1 ★Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specific	Themoval from State		osition (Name of ematory or other plac Valley Mei			Timoniu		
MARCH 15. Baltimore.	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Licer			22. Name and Addres	an of Facility	·			ome, Inc.
¥ 60	an III De		1 Tallay	2 Ludl	0	1050 York				21204	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plical ons that caused the d one cause on each line.	eath. Do not er	nter the mode of dyin	ng, such as cardiac	or respiratory arr	est,	Init	oproximate terval Between nset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. BLADDER CA						Or	iset and Death
	Examiner			Due to (or as a cons	sequence of):						
	P. T.	ner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	b. Due to (or as a cons	sequence of):					_	
	ecuter and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C							
8760.	cate be executed oblysician and the burial-transit		rooding in dodain, Edot	Due to (or as a cons	sequence ot):						
687	fficate g phys	edical		d							
Box	eath certific attending p for use as	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		Пен			23d. Date	of delivery	
O. B.	e deat he att	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time		☐ Ectopic pregnance ☐ Other (specify)	у		Mon	th Da	y Year
σ,	hat the de ed by the detached		9 ☐ Unknown Part II. Other significant conditions of	contributing to death but not	resulting in the	underlying cause give	on in Part I	23e Did tot	pacco use contri	bute to the c	rause of death?
JOHN TRACEY Vital Records.	uires tha signed Id be det	d by	The state of the s	on the control of the	rooding in the	andonying dadoo give	on mer are i.				y 4 🗆 Unknown
TRACEY	w requir s been s should I	Completed						24a. Was a	n 24b. W	ere autopsv	findings available
N T E	sician: The law certificate has b irector, page 2 s	mo d						autops perforr	ned? pr	for to complete the complete th	etion of cause of
JOHIN Vital	ian: '	Be C	25. Was case referred to medical examiner?				26. Place of Death	1 ☐ Yes 2 (Check only on		∐Yes 2	
of V	hysic this ce	၉	1 Yes 2 No	Hospital: 1 Inpatient 2			4 LI Nursing Ho	me 5 Reside	ence 6 X Othe	r (Specify)	HOSPICE
on c	ding Phys h. After this funeral di	ion:	27. Manner of Death 1 Natural 5 Pending Pending investigation	28a. Date of Injury (Month, Day, Year	r) 28b. Time (Injury	Work	yat ⟨? Yes 2 □No	28d. Describe ho	w injury occurre	d	
Division	Attender r death	ertification:	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Injury - A	t home, farm, st			28f. Location (St.	reet and Numbe	r or Rural Ro	oute Number,
وَ	tal or	Cert	4 Homicide determined	building, etc. (Sp	еспу)			City or Town	i, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		(Check only 2 Medical Exar	nysician: To the best of my niner: On the basis of exam	knowledge, dea nination and/or i	th occurred at the tir	ne, date and place, pinion, death occurr	and due to the c	ause(s) and mar ate and place, a	nner as state	ed. e cause(s)
	o the ithin 2 o the	Medical	29b. Signature and title of certifier	itionerner stated.		29c. License			9d. Date signed		
	FSFÖ		Mar Thomas	Mahellan	1001	10	R1469	_		6-0	
	7		30. Name and address of person who	completed cause of death (I	Item 23a) (Type	, Print)	NITO	41		00	
211			SR. DOROTHEA MAHO	OLLAND, CRNP	2300 D	ULANEY VA	LLEY RD.	TIMONII	JM, MD 2	1093	
4	Sta		31. Date filed (Month, Day, Year)	09 32 Registrar's Sig	gnative	ake					

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryland / I	Depa <i>Cei</i>	artment of F <i>rtificate of I</i>	lealth and M <i>Death</i>		iene 2 0 0 1	9 08327
			1. Decedent's Name (First, Middle, Las	t)				2. Date of Deat	th	3. Time of Death
	Physicia /Medic	_	Patrick A. Vo	na				Month March 1	.4,2009 Year	10:30P M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	ath
		Щ	Dove House				inster		Carroll	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last bi ▼ M 2□ F 88	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year) 9. Bi	rthplace (State or Foreign country)
	Director		127-05-9874 Usual Residence of Decedent		113.			October	10,1920	New York
	and ow		10a. State 10b. County	10c. City, Tow	n or Lo	cation				10d. Inside City Limits
	Mary fied	to	New York		Owe	0.0				1 ☐ Yes 2 ☐ No
	r 28a	Director	10e. Street and Number		Owe	10f. Zip Code		1	0g. Citizen of What C	ountry?
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Medical Examinser must be neaffined at		104 Southside Dr	ive		1382	7		USA	
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13.	Vas Decedent of H	ispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No-	14. Race - Am	erican Indian,
9	after or ite	E.	1 ☐ Never Married 2X Married	1∭Yes 2 No IfYes, Give		Tes, specify Cuba	Specify:	nican, etc.)	Black, Whi	-
Maryland 21215-0036	urai",	d by	3 Widowed 4 Divorced	Year or Dates: Army			opecny.			
5-	72 h "natu	Completed	15. Decedent's Ed (Specify only highest gra	ucation 16a de completed)	. Deced (Give	lent's Usual Occup kind of work done	ation during most of workir f)	ng	16b. Kind of Business	s/Industry
12	vithin	m d	Elementary/Secondary (0-12)	College (1-4or 5+)			1)		T	0.
2	iled v Hygid ther int, il		12 17. Father's Name (First, Middle, Last)		Man	ager	18. Mother's Name		Furniture	Store
an	d be f	Be	Domenic Vona				Pasqua S		naidon odmano,	
<u> </u>	hould mark matic	၉	19a. Informant's Name/Relationship (Type Print) 19k	Mailin	n Address (Street	-	-	; City or Town, State,	Zin Code)
Z	nd 2 s itth au 27 is r trau	1	Sandra Konzal	DTR.		991 Grave			d, Md. 210	
Baltimore,	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. item 27 is marked other than "naturar", or items 23a or 28a-f show other traumatic event, if we Medical Examiner must be notified at	1	20a. Method of Disposition	20b. Place of	f Dispo	sition (Name of	D	ate	20c. Location - City o	r Town, State
9	permit. Pages Department of Important: If its any injury or o		1 ☐ Burial 2 🄀 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	-	natory or other plac	3-17-2	2009	Baltimore	City
=	ortar	i	21. Signature of Fuperal Service Licen			, Name and Addre			Funeral Ho	
ñ	any any any	-	Il tell						am. MD. 2	
			23a. Part 1. Enter the disease, or comp	lications that caused the de vh. Do	not ent	er the mode of dyin	such as cardiac o	r respiratory arm	est,	Approximate
	Physician		shock, or heart failure. List only immediate Cause (Final disease or condition	one cause on each line.	-l c	W	1101	2hma		Interval Between Onset and Death
	/Medical		resulting in death)	a. Due to (or as a consequence	of):	1910	2/24	01-01		MOMO
	Examiner			h	•		Ž			
4.5	p <u>∺</u>	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	Jij.					
12st	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с						
68760,	Attending Physician: The law requires that the death certificate be executed refeath. redeath. sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	<u>e</u>	resulting in death) Last	Due to (or as a consequence	01):					
87	physi the t	edical		d					-	
	certifi iding se as	Me	IF FEMALE:	23c. If yes, outcome of pregnancy					201 201 (1	
Box	atter for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal death		Ectopic pregnanc Other (specify)	y		23d. Date of de Month	Day Year
Ö	w requires that the death certi been signed by the attending should be detached for use a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	3 [Journel (specify) _				
σ.	that ned b deta	<u>a</u>	Part II. Other significant conditions of	ontributing to death but not resulting i	n the ur	derlying cause give	en in Part I.	23e. Did tot	acco use contribute t	o the cause of death?
rds	quires n sign	d by				_		1 □ Ye	s 2 No 3 F	robably 4 🗆 Unknown
ဝွ	w rec	lete						24a. Was a	24b. Were a	utonsy findings available
Division of Vital Records,	The law te has age 2 a	Completed						autops perforr	ned?// death?	
ta	an: rtifica tor, p	BeC	25. Was case referred to medical				26. Place of Death		/	s 2 No
>	nysici iis ce direc		examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/O	utpatien	t 3 DOA Othe			/	ecity) DOUELBUSE
0	ng Ph Iter th	Ë	27. Manny of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year) 28b.	Time of	28c. Injur Work		_	w injury occurred	
. <u>ö</u>	endir sath. or: Al	äţ	Accident investigation		, , ,		Yes 2 □ No			
: <u>ĕ</u>	r Att	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, stre	et, factory, office	2	8f. Location (St. City or Town	reet and Number or F n, State)	ural Route Number,
	oital curs af						W.			
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical		ysician: To the best of my knowledg Iner: On the basis of examination and and manner stated.						
	ithin (Mec	29b. Signature and title of certifie	and manner stated.		29c. License	e number	2	9d. Date signed (Mon	th. Dav. Year)
	F 3 F ŏ)				67171		3/16/71	2001
	14.	-	30. Name and address of person who	empleted cause of death (Item 23a)	(Type	Print)	ارات		1.010	
'	12x1		Your frahac / 50	5 South Carton	Shr	et likst	MUSTERME	21157		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	المريد الماريد	<u> </u>	1.000			
	Registra	ar	MAR 1 7 2009	Cenus B. gar	Kal					
	MH 17 Rev 1/20		USAVI.							

			1 - For State Registrar			nd / Dep	artment of rtificate o	Health	and Mer	ntal Hyg	211119	08328
			Registrar Decedent's Name (First, Middle)	e. Last)			i lilicale 0	Dealii		Date of Deat	99. NO	
	Physici		Delores		Van	20 0	_			Month	Day Year	
4	/Medio Examir		4a. Facility Name (If not institution	n, give street and numi	ber)	ghav	4b. City, Town	. or Location		wat	4c. County of Dea	1
-	LXaiiiii	ici	14 11	spital	,			timor			10. Obdiny of Boo	2011
	Funeral	Т	5. Social Security Number	6. Sex 7	Age (In yrs.	last birthday)	If Under 1 Yea Months Day	r If Under	24 Hrs. 8. 1 Min.	Date of Birth (Month, Day,	year) 9. Bi	rthplace (State or Foreign ountry)
	Director		216-24-8100	1□M 2 X F	79	Yrs.	MOTITIS Day	S Hours	00	2 cembe	-12,1929 M	aryland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
	Maryl f sho	호	Maryland Balti	more		•	sville					1 Yes 2 KNo
	r 28a	Director	10e. Street and Number				10f. Zip Code	e		10	ng. Citizen of What C	ountry?
	72 hours after death with the Marylar "natural", or items 23a or 28a-f show dical Expression must be notified at		912 S. Rollin	g Rd., Suí	te 309		21228	3			USA	, , , , , , , , , , , , , , , , , , , ,
	deat	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.		Was Decedent o If Yes, specify Cu	f Hispanic Or	igin? (Specify	Yes or No-	14. Race - Am	erican Indian,
36	or ite		1 ☐ Never Married 2 ☐ Marr		X No	1	il res, specily Co 1 □ Yes 2 □ N			in, etc.)	Black, Whit	
8	ural",	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Date	es:		A				Specify: Wh	ite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ha Madigal Experience must be natified at	Completed	15. Decedent (Specify only highes	's Education of grade completed)		16a. Dece (Give	dent's Usual Occ kind of work don DO NOT use reti	supation ne during mos	t of working		6b. Kind of Business	*
12	withii iene. than	E C	Elementary/Secondary (0-12)	College (1-4	or 5+)	ľ	istrativ			۱ ا	Jniversity Dental	of Maryland School
	be filed Ital Hygi Ital other event, I	BeC	17. Father's Name (First, Middle,	Last)		Humin	1001001	т			laiden Surname)	5011001
Maryland	e g 45 p	일	C1yde	Dea	n			l Ni	ina		,	Grammer
ary	and N	_	19a. Informant's Name/Relations	nip (Type. Print)		19b. Mailir	ng Address (Stre	et and Numbe	er or Rural Ro	oute Number,	City or Town, State,	Zip Code)
	rtr		Charles R. Vaug	han (Son)		1081	Downton	Rd., H	laletho	orpe, N	ID 21227	
Baltimore,	jes 1 a t of Hea lf item or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □ Removal from Str	20b. F	Place of Dispo semetery, crer	sition (Name of natory or other p	/ace)	Date	2	0c. Location - City or	Town, State
Ë	permit. Pages Department of Important: If it any Injury or o		4 □ Donation 5 □ Other (S)	pecify) Entombm	ent Lo	udon P	ark Ceme	etery 3	3/18/09) [Baltimore,	Maryland
3all	permit Depar Impor any In		21. Signature of Funeral Service I	icensee		22	. Name and Add	ress of Facilit	Loudon	Park	Funeral H	ome
_	TO 2 4 0										ore, MD 21	229
	51.50	2 10	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau only one cause on eac	sed the death h line.	h. Do not ent	er the mode of d	ying, such as	cardiac or res	spiratory arre	st,	Approximate Interval Between Onset and Death
-	Physicían /Medical		Immediate Cause (Final disease or condition resulting in death)	-a. Mul	iti or	gen	Farl	ue				1 deu
	Examiner		Transity of the same	Due to (or	as a consequ	uence of):	carons Nasce					2
		e.	Sequentially list conditions,	b. Due to for	3-50 e	Second S	Sis					3 days
	d ansit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Pny	211000							if due
oʻ	an an rial-tr	Exa	resulting in death) Last	C. Due to (or	as a consequ	uence of):		·	· · · · · · · · · · · · · · · · · · ·			, , , , ,
8760,	sate be executed shysician and the burial-transit	cal		d								
89	artifica ing ph	Physician/Med	IF FEMALE:									
Box 6	eath certific attending p for use as	an/l	23b. Was decedent pregnant	23c. If yes, outco	me of pregna th 2 ☐ Fetal] Ectopic pregnar	ncv			23d. Date of de	,
Ö	the a	sici	in the past 12 months? 1 □ Yes 2 ZNo 9 □ Unknown	4 ☐ Pregnar	nt at time of d		Other (specify)				Month	Day Year
P.O.	hat the sed by	Ph	Part II. Other significant conditio	ns contributing to deat	h but not resu	ulting in the ur	iderlying cause o	iven in Part I		23a Did tobs	acco use contribute to	the course of death?
Division of Vital Records,	uires that the de	d by	Dissemino	1 ,	17x 1 fet	بأجيده	v Coa	i 1	7(7)	1 ☐ Yes		obably 4 Unknown
င္ပဲ	w requir s been s should I	Completed	Cananah	14 15	2. 0.		1	Jucaci				
æ	he faw e has ge 2 s	E D	Character	Vicini -	mai ^	1	rypu	rusi	m ;	24a. Was an autopsy perform	i prior to i	topsy findings available completion of cause of
<u>ra</u>	siclan: The certificate h		25. Was case referred to medical	bshuh	ue Pu	mor	my Di	Seus		performe 1 □ Yes 2		2 No
>	ysick s cer direct	o Be	examiner? 1 ☐ Yes 2 No	Hospital:	atient 2 🗆	ER/Outpatien	3 7 704	No o v	of Death (Che		ce 6 □Other (Spe	
<u></u>	ding Phys h. After this funeral dir	Certification; To	27. Manner of Death	28a. Date of I	njury	28b. Time of	28c. Inj	ury at			injury occurred	city)
<u>ō</u>	ath. ath. nr: Af	atio	Natural 5 Pending 2 Accident investig		Day, Year)	Injury		ork? ⊒Yes 2.⊟1	No			
<u>\S</u>	r Atte	ti ii	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	28e. Place of	Injury - At ho	me, farm, stre	et, factory, office		28f. L	ocation (Stre	et and Number or Ru	ıral Route Number,
	ital o urs afi ral Di lled ir								1		ŕ	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. or the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	Consect only 2 Intedical E	Physician: To the be xaminer: On the basi	s or examinar	wledge, death	occurred at the restigation, in my	time, date an	d place, and d	due to the cau	use(s) and manner as	s stated.
	thin 2 the omple	Med	one) 29b. Signature and title of certifier	and manner	stated.							
	S 2 × 12		and the or certifier					se number	01		d. Date signed (Month	
		-	30. Name and address of person w	the completed server	of doath /lt-	22a) /T 5		500	,01		w-ch 13,	2007
			Taxia Robe	Km - m		3001	Sour	-11-	0.14	R. 11	Α	10 21220
F	Stat	e	31. Date filed (Month, Day, Year).	32. Jeg	trar's Cianat			· vtur	1000	1 mil	more 11	10 4160
	Registra	ar	MAR 17	SUB Die	ر انها	1. A	No					

DHMH 17 Rev 1/2001

09-01904 John Robert Ward Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 08329

		n- For State Registrar				Certific	cate of	Dea	th				Reg. N	0.				
Physicia Medical Examir			ert	War								Date of Month March	Death Day 7, 200	Yea		3. Time of Death 0610 hrs		
,		4a. Facility Name (if not institute 1602 Joplin Street	tion, give s	treet and nui	mber)		4		Town, or I	Location o	of Death			4c. County o	of Death			
Funeral Director		5. Social Security Number 216-78-6083	6. Sex	1 2F		yrs. last bii 47	rthday) Yrs.	If Und	der 1 Year ths Days				8 19		9. Birt Cou Mar	hplace (State or Foreign untry) yland		
any.		Usual Residence of Decedent 10a. State 10b. Cour	by		1100	. City, Towr	or Locatio									404 1-34 00 15 0		
* 1	ţ	MD N/	•	·	100		timor	:e								10d. Inside City Limits 1 X Yes 2 No		
r death with the Maryland or items 23a or 28a-f sho must be notified at once.	I Director	10e. Street and Number 1602 Jopli	n St	reet				10t. Zij	21	224		î×	10g. C	itizen of Wh		itry?		
more, MD 21215-0036 Pages I and 2 should-be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Exampler must be notified at once	by Funeral	3 Widowed 4 X	Married Divorced If	2. Was Dece Armed Fo 1 Yes Yes, Give Year r Dates:	rces?	No	If Ye	s, spec Yes 2	ent of Hisp ify Cuban, 2X No	, Mexican, specify:	Puerto R	ican, etc.		White Specify:	, etc. Whi			
nore, MD 21215-0036 gges I and 2 should be filed within 72 hours after nt of Health and Mental Hyggene. it: If Item 27 is marked other than "natural", other traumatic event, the Medical Examiner.	Completed	15. Decedent's Education (S Elementary/Secondary (0-1 10		College (1-		_	Decedent' during mo	st of wo						Kind of Bus Home Impro				
5-0(led wi tygien other		17. Father's Name (First, Mide					-		1	18.Mother	s Name (F	Name (First, Middle, Maiden Surname)						
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medical	ä		Ward							Agr			ck1					
ore, MD 2 is 1 and 2 should of Health and M If Item 27 is m		19a. Informant's Name/Relation William Ward] 3	3521 N	lary	7 Ave	nue,	Ba1t		e, M		214			
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If Item 27		1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: 4 Donation 5 Other Specify: 03/1:)9 I	Location - Baltim	ore,			
Balt permit. Departi Import Injury	1	21. Signature of Funeral Server reeff. Williams 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD												nc.	1228			
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Appr												Approximate Interval Between Onset and				
xaminer		Immediate Cause (Final disea or condition resulting in death		arcoti e to (or as a						fent	any1)	and	alc	oho1		Death		
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause.	e	e to (or as a	conseque	ence of):					-			5-133				
ecuted and - transit	EX	(Disease or injury that initiated events resulting in death) Las		e to (or as a	conseque	nce of):												
0, e be exec sician ar burial - ti	dica	X UNPENDED		MENDED	23a,2	27 , 28a	a-f, p	perM	ΛE, g	889	3/18/	09 I	T					
		IF FEMALE: (3b) Was decedent pregnant in past 12 months?	the	23c. If yes, o	rth int at time		2 Feta	l death er (Spe		Ectopic	pregnanc	у	2	3d. Date of o		ay Year		
P.O. Es that the greed by the detached		Part II. Other significant con	litions co			not resultin	ig in the un	derlying	g cause gi	ven in Par	rt I.				_	he cause of death?		
cords, I law requires has been sign 2 should be	eted			-			•					24a. W				opsy findings available		
iton of Vital Records, P.O. Box 6 flending Physician: The law requires that the death cer earth. from After this certificate has been signed by the attending the funeral director, page 2 should be detached for use	Completed by											1 ✓ Y	utopsy erformed es 2	de	ior to co eath? ✓ Yes	ompletion of cause of		
Vital ysician: his certif director,	ď	25. Was case referred to medi examiner?		oital:	patient	2 EB/O	utpatient		26.Place	of Death (Other:		- "	Davis	lence 6 🗸	2 011	0		
n of Viding Physical After this funeral dir	의	1 ✓ Yes 2 No 27. Manner of Death		28a. Date o	finjury		Time of Inj		28c. Injury	-	Nursing I			ience b		Scene		
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Division Hospital or Attendia 24 hour after death. Puner I Director A	=	3 Suicide 6 X Co	uld not be ermined	28e. Place (Specify)	of Injury	- At home, fa	arm, street,	factory	, office bu	uilding, etc	. 28 B	of Tow alti	n (Street n, State) More	and Number	or Rura Jop L	al Route Number, City in St		
	<u>ल</u> (29a. Certifier 1 Certifying Check only 2 Medical E	aminer:Or	To the best the basis of d manner sta	examina													
F » F »	E Z	29b. Signature and title of cert		441)			290	c. License				- I	Date signed		th, Day, Year)		
	3	30. Name and address of person	n who com	pleted cause	of death	(Item 23a)			J.J.IV.		=		IVIE					
				t Medical		ner 11	1 Penn S		, Baltim	ore, M	21201							
Sta Registr	te ³ ar	31. Date filed (politic Day, Yea	2009	Reg	istrar's Si	gnare	park	7						7-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 05 P M David E. Williams Marc 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) County of Death Examiner Square secq 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Min. Months Days 1**X** M 2 □ F Hours Director 22,1948 Maryland 218-48-1184 60 November Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and injury or other traumatic event, the Medical Examination and injury or other traumatic event, the Medical Examination and injury or other traumatic event, the Medical Examination and injury or other traumatic event, the Medical Examination and injury or other traumatic event. 1 ☐ Yes 2 No Director Md. Balto. White Marsh 10f. Zip Code 10e Street and Number 10g, Citizen of What Country? Funeral 7614 Chesterfield Way 21237 USA 12. Was Decedent Ever in U.S. Armed Forces? 1▼DYes 2 □ No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married David Baltimore, Maryland 21215-0036 1 ☐Yes 2¶ No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Forklift Service Manager Vince's Forklift Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Merritt E. Williams Viola Watson မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherrie B. Williams Spouse 7614 Chesterfield Way White Marsh, Md. 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview 3-14-2009 Balto. City, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Stekan 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1716 ardiac disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Prospital or Attending Physician: The 24 hours after death.
Funeral Director: After this certificate h 1 □Yes 2 No 2 □No 1 TYes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **1**No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Gruce Han MO

State Registrar Drive Baltimore, MD. 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

tranhlin

Han

MAR 1 7 2009

Dr. Grace 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician Mark Earl Williams 2009 12:45 ZΜ March 14. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 2804 Upridge Court Apt. Parkville 8. Date of Birth (Month, Day, Yes 08/19/1927 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year! Months 1 X M 2 □ F Days Hours 216-20-1602 Baltimore, MD Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County if than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Baltimore Parkville Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 21234 U.S.A. 2804 Upridge Court Apt. A Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1X1Yes 2 ☐ No Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give YWII 1 □Yes 2 No Specify Specify: White ğ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irene Roberts Jacob Earl Williams traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health au
Important: If item 27 is
any injury or other trau 2804 Uprickye Court Apt. A, Parkville, MD 21234 Helen Williams/ Wife 20b. Place of Disposition (Name of Completely crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/20/09 Owings Mills, 4 ☐Donation 5 ☐ Other (Specify) Veteran Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

And S Funeral Chapel & Cremation Services-Parkville B800 Harford Rd. Parkville, MD 21234 23a/Part/. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heartrailure. List only one cause on ea. Approximate Interval Between Onset and Death Immediate Cause (Final dis a cor condition resulting in death) DAYS lehy Dration **Physician** /Medical Due to (or as a consequence of) Examiner Cardiony opathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and strans Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No Ö the 9 Unknown 9 Unknown signed by the ٣. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ c Obstructle 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2X No certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes Physiclan; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 1 X Natural 5 Pending investigation after death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 \ Homicide within 24 hours a the Hospital 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature AHENDINGMD D17118 Mar 16, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3512 MD WARIZ State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2

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Physician
/Medical
Examiner
70

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

		For State Registrar	nate of Marylant		rtificate of l			g. No.		
ði.		Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day	Year	3. Time of Death
Physicia /Medic		SARAH F. WATKINS					MARCH 1			9:15 P ^M
Examin	er	4a. Facility Name (If not institution, give stre				Location of Death			y of Death	non! a
		FORT WASHINGTON HOS 5. Social Security Number 6. Sex	PITAL 7. Age (In yrs. la	ant hirthday	FT. WASH	INGTON If Under 24 Hrs.	8. Date of Birth	PRINC	CE GEO	
uneral irector			2×F 83	Yrs.	Months Days	Hours Min.	(Month, Day, OCT. 5,		GA GOUNT	ace (State or Foreign try)
at ow	ľ	10a. State 10b. County	10c. City	, Town or Lo	ocation				10	d. Inside City Limits
a-f sh fied	ţò	MD PRINCE GEO	RGE'S OXO	N HIL	L					1X Yes 2 □ No
or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of	What Count	try?
23a	lal	1410 OWENS ROAD			20745			SA		
ltems ner m	Funeral	11. Maritai Otatus	Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - America ick, White, e	
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Ď	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🏹 No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Speci	DLA	
"nati edica	Completed	15. Decedent's Educati (Specify only highest grade co	on ompleted)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of worki	ng 1	6b. Kind of E	Business/Ind	lustry
than he M	duc	Elementary/Secondary (0-12)	College (1-4or 5+) YR		MAKER	,		PRIVAT	ГE	
other ent, t	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, M	aiden Surna	me)	
rked tic ev	10 B	WYATT MADDOX				ALBERTA	ALLEN			
s ma auma		19a. Informant's Name/Relationship (Type.	Print)	19b. Maili	ng Address (Street	and Number or Rura	al Route Number,	City or Towr	, State, Zip	Code)
n 27 ner tr		JOAN F. WATKINS / D			HENDERSON		PLE HILL		2074	
If Iter or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Rem	CA	lace of Dispe emetery, cre	osition (Name of matory or other place	ce)	Date 2	Oc. Location	- City or To	wn, State
tant: Jury		4 □ Donation 5 □ Other (Specify)			NATIONA			UITLA		
any ir		21. Signature of Fineral Service Licensee	DeSHAUN WAT		2. Name and Addres	ss of Facility MAR AND ROAD	SHALL'S SUITLAN		2074	
		23a. Part Enter the disease, or complicat shock, or heart failure. List only one	ions that caused the death cause on each line.	. Do not en	ter the mode of dyir	g, such as cardiac o	or respiratory arre	st,		Approximate Interval Between Obset and Death
sician		Immediate Cause (Final disease or condition resulting in death)	July C	10	Les	1 18C	eed			tay
edical ıminer			Due to (or as a consequ	ience of):	uni	~			,	year)
ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (dr as a consequ	ience of):	tia					fears
g physician and as the burial-transit	sal Exa	resulting in death) Last	Due to (or as a consequ	ience of):						
g phy as the	edical									
To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	If yes, outcome pf pregna 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3	□Ectopic pregnancy □ Other <i>(specify)</i> _	/			ate of delive lonth	ry Day Year
ned b	by Pt	Part II. Other significant conditions contrib	outing to death but not resu	Ilting in the u	inderlying cause giv	en in Part I.	23e. Did tob	acco use cor	tribute to th	e cause of death?
en sig uld blu							1 □ Ye	s 2□No	3 ☐ Prob	ably 4 ∭Unknown
ate has bee	Completed						24a. Was an autopsy perform	/	prior to con death?	osy findings available inpletion of cause of
ctor,	Be C	25. Was case referred to medical examiner?				26. Place of Death				
this ce	To E	1 ☐ Yes 2 No Hos		ER/Outpatie		4 Li Nursing noi	me 5 Reside)
r: After t e funera	ation:	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2 □ No	28d. Describe ho	w injury occu	rred	
al Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At ho building, etc. (Specify		reet, factory, office	1	28f. Location (Str City or Town		ber or Rura	l Route Number,
le Funera	Medical (lan: To the best of my known: On the basis of examination and manner stated.							
To tl	Me	29b. Signature and title of certifler	Clan	_ Jun	29c. Licens	6046		d. Date sign		Day, Year)
		30. Name and address of person who comp				. WASHING	STON, MD	2074	4-5164	•
Sta Registi		31. Date filed (Month, Day, Year) MAR 1 7 200	32. Egistrar's Signa	d. A	hare					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08333 State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Williams Jessie olton AM /Medical Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Days Hours Min. 212-08-5927 Director Trinidad 3 Tobago Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Mydical Evaminer must be notified at **Funeral Director** 1⊞Yes 2□No MI Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1221 Wood bourne Ave 21239 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Ho If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married þ 1 ☐ Yes 2 7LNe- Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ietaru HOST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Beckles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1221 Woodbourne Ave Boutimore, MD 21239 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) . Pages 1 Department of Important: If it any Injury or o oonce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3.16.2009 Buttimore, MI 4 ☐ Donation 5 ☐ Other (Specify) Lwood 22. Name and Address of Facility Loughn C. Greene Funeral Services 21. Signature of Funeral Service Licensee 4905 York 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Proble **Physician** my oc ordisal disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) use as the burial-transi Exami Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Division of Vital 2 40 1 ☐ Yes ospital or Attending Physician: hours after death. uneral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐Yes 2 ☐ No completely filled in by the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mys, cion H0059540 moran II, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

09-01988		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Gerald Williams	1	State of Maryland / Department of Health and Mental Hygiene -For State Certificate of Death Reg. No. 2009 0833
Dhysicia		tegistrar 2. Date of Death 3. Time of Death 3. Time of Death
Physician Medical Examin	_	Gerald Williams Month 10, 2009 Year 0058 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
1		Good Samaritan Hospital Baltimore 5 Social Security Number
Funeral		Months Days Hours Min (a) Foreign
Director		214-44-2407 12-16 6 Yrs. Molitus Days 11003 Mill 8-24.1947 Country) MD
any	ŀ	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
nd show	٦	MD Baltimore 1 2 No
Maryla 28a-f d at o	ect	10e. Street and Number
death with the Maryland or items 23a or 28a-f show any must be notified at once.	Funeral Director	39a5 Wilke Ave 21aWas Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,
ath wit tems 3	nera	1 Never Married 2 Married 3 Married
ter de		3 Widowed 4 Letvorced If Yes, Give Year 1 Yes 2 No specify: Specify: Specify:
136 hin 72 hours after e. then "natural", edical Examiner	g S	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
6 72 ho an "n ical Es	ig e	Elementary/Secondary (0-12) College (1-4 or 5+)
5-0036 led within 7 Hygiene. I other than	Completed	17. Father's Name (First, Middle, Last) Welder General Moters 18. Mother's Name (First, Middle, Maiden Surname)
21215-00 uld be filed wi Mental Hygien marked other c event, the M	Be C	Nolan T. Williams Marie Sheldon
	To	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MD od 2 sho lith and m 27 is		Lillie M. Cunninghan 2732 W. Lafayette Ase Baltimore MD 20s Method of Disposition 20s Method of Disp
nore, Nages I and ages I and of Health II: If item other trau		1 Usurial 2 Cremation 3 Removal from State crematory or other place)
·= E 2 4	- 1	4 Donation 5 Other Specify: Garrison Forest 3.19.2004 Baltimore, MD
Balti permit. Departm Imports		21. Signature of Funeral Service Licensee Vous C. Greene Foreral Services 12. Name and Address of Facility Vougna C. Greene Foreral Services 12. Name and Address of Facility Vougna C. Greene Foreral Services 12. Name and Address of Facility Vougna C. Greene Foreral Services
Physician		23a. Part I. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart
Medical		failure. List only one cause on each line. Immediate Cause (Final disease a, Hypertensive Atherosclerotic Cardiovascular Disease Death
xaminer		or condition resulting in death) Due to (or as a consequence of):
	-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
	Examine	cause. Enter Underlying Cause (Discoss or injury that initiated C.
led msit	Exa	events resulting in death) Last Due to (or as a consequence of):
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Box 68760, e death certificate be the attending physic ed for use as the bur	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year Other (Specify)
Sox death of e atten for us	ysic	1 Yes 2 No 9 Unknown 4 Pregram at time of 5 Other (Specify) 9 Unknown
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Division To the Hospital or Attend within 24 hours after death To the Funeral Director:		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
To the within To the comple	Medical	Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier. 29c. License number 29d. Date signed (Month, Day, Year)
	Σ	29b. Signature and title of certifier 29c. License number 29c. License number O.C.M.E. March 10, 2009
		(chorely)
3		30 Name/and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
	tate	31. Date filed (Month Day Year) 31. Registrar's Signature
Regis		MAR 17 2009 Ceneva B. gares

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2009 Month **Physician** Louise Agnes Watkins 11:10P.M Mar. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Examiner Crownsville Fairfield Nursing Home 9. Birthplace (State or Foreign 1916 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Days Months Hours 1 □ M 2 □ MF <u>212-12-</u>3939 92 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Nectical Evanting or must be notified at 10a. State 10b. County Chester Queen Anne's 1 ☐ Yes 🏋 No Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 1423 Cox Neck Road 21619 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify <u>る</u> 3√ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Circle Restaurant Elementary/Secondary (0-12) College (1-4or 5+) Cook <u>11th grade</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle, Maiden Surname)
Beulah Tilghman å Opher ္ပ John 19b. Mailing Address *(Street and Number or Bural Boute Number City Marky Pate Aid Code)* 1619 1423 Cox Neck Road Chester, Marky Pate Aid Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau Pamela Watkins/ Niece 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition Woodlawn, Maryland 3/16/09 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reistesrstown Rd Baltimore.Md 21215 21. Signature of Funeral Se 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final **Physician** disease or condition resulting in death) 244 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760. attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 ☐ Other (specify) P.0. cate has been signed by the page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 含 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 **□**No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

24 hours after death. Funeral Director: A completely within 2

> State Registrar

29b. Signature and title of certific

31. Date fled (Month, Day)

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

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and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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AMENDOTTHEN 1260 F DEPAS INGEN So Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month March 2009 **Physician** Day 12:02 PM Williams /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Windsor Mills Baltimore 8020 Johnnycake Road If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🕇 F 97 180-09-3071 Director Nov. 10, 1911 Pennsylvania Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evaminar must be notified at 1 ☐ Yes 2 ☑ No Director PΑ Schuykill Pottsville 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 7 Hemlock Road 17901 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumeth. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Noah Haslam Laura Butts 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8020 Johnnycake Road, Windsor Mill, MD 21244 Darlene Sterner (daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Odd Fellows Cemetery 2009 St. Clair, PA 21. Signature of Funeral Servi e Lio nsee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on- cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): veeles /Medical Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine artic stenacis and burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☑ No P.0. the 9 I Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

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Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Daughter's Hospital: Other: 4 Nursing Home 5 esidence 6 Other (Specify Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hosping.
within 24 hours after
To the Funeral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0-53636 march 10, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 KEVIN CAPLION, MB 10700 21074 charte 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 17 2009 Registrar

Division or Vital Records, P.O. Box 68760,

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Baltimore, Maryland 21215-0036

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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1	/Medi		4a. Facility Name (I	f not institution, giv	e street and number)		4b. Cit	y, Town, o	r Location of Death		4c. (County of Deat	h
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16/3	Funeral		5. Social Security N		ex 7. Ag □M 2 X F	e (In yrs. last birt 88	hday) If Und Month	s Days	Hours Min.	8. Date of Bir (Month, Da 11/19	th ay, <i>Year)</i>	9. Birti	nplace (State or Forei untry) RYLAND
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	/land ow at		10a. State	10b. County		10c. City, Town	or Location						10d. Inside City Limi
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	th the or 28	Director	10e. Street and Nu	mber			10f. 2	Zip Code			10g. Citiz	en of What Co	untry?
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	er de la	Funeral	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Dec	cedent of F pecify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	D- 1	4. Race - Amei Black, White	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by F	1 X Never Marr 3 □ Widowed	ried 2 Married 4 Divorced	1 ☐ Yes 2 ☐X If Yes, Give Year or Dates:	NO	1 ☐ Yes	2[X No	Specify:			Specify: V	HITE
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Ž	should nd Me mark matic	10	JOHN J. 19a. Informant's N	ame/Relationship (Type. Print)	19b.	Mailing Addre	ss (Street	and Number or Rui			Town, State, Z	(ip Code)
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7	Shysik this o	7	1 ☐ Yes 2 ☐		Hospital: 1 Inpati		tpatient 3	DOA				Other (Spec	cify)
Division or Vital Records, P.O	Attending Physician: r death. ector: After this certifics by the funeral director, p	ion:	27. Manner of Dea 1 Matural	5 Pending	28a. Date of Inju (Month, Da	ly Year) 28b.	ime of njury M	28c. Inju Wo	ryat rk?]Yes 2 ∐No	28d. Describe	now injury	occurred	
isic	or Attend ifter death Director: , in by the f	icat	2 Accident 3 Suicide	investigation	e 28e. Place of in	ury - At home, fa			1162 5 110	28f. Location	Street and	d Number or Ru	ıral Route Number,
Οį<	5 £ £ ⊑	Certification:	4 ☐ Homicide	determined	building, e	tc. (Specify)		,		City or To	wn, State)		
_	spital ours al	C C	29a. Certifier	1 Certifying Pl	nysician: To the best	of my knowledge	, death occurr	ed at the ti	ime, date and place	, and due to the	cause(s)	and manner as	stated.

1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie

29c. License number H0054424 29d. Date signed (Month, Day, Year)

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ⋈ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cyrus Asadi, 20 E. Timonium rd #29 Timonium, MD 21093

31. Date filed (Month, Day,

State Registrar

Medical

To the Hospital or Attending Physician: The law requires that

within 24 hours after death.

To the Funeral Director: /

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08339 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year Winters 11:42 PM W 2009 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9. Birthplace (State or Foreign Manning 1702 8. Date of Birth (Month, Day, Year) 04-02-1936 5. Social Security Number 7. Age (In yrs. last birthday) Days 1 XM 2□ F 219-32-3976 72 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits

Funeral Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be exec within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician an completely filled in by the funeral director, page 2 should be detached for use as the burfal-trip Division of Vital Records, P.O. Box 68760,

ctor	MD	Anne Ar	undel	Haru	ında1e	<u> </u>						1 🗆 1	res X□No
ire	10e. Street and Nu	mber				10f. Zip Code			10	g. Citi	zen of What C	ountry?	
a D	1702 Man	ning Road	d			2106					U.S.	Α.	
Be Completed by Funeral Director	11. Marital Status	ied 2X Married	12. Was Decedent Armed Forces? 1 ☐ Yes 🏖		13. Wa	s Decedent of es, specify Cul	Hispanic Or an, Mexica	rigin? (Speci n, Puerto Ri	ify Yes or No- can, etc.)		14. Race - Am Black, Whi		1,
d by	3 ☐ Widowed	_	If Yes, Give Year or Dates:		1 []Yes 2∭XNo	Specify	:			Specify:	White	
plete	(Spec	15. Decedent's E	ade completed)		a. Deceder (Give kir life. DO	nt's Usual Occu nd of work done NOT use retire	pation during mos ed)	st of working	11	6b. Kir	nd of Business	s/Industry	
E	6	ondary (0-12)	College (1-4or 5)+)	Truc	k Drive	er			Co	ncrete	Compa	ny
	17. Father's Name Freedm								First, Middle, M		Surname)		
٩	Freedin		= 15				Edn	na Ro	dheader				
		ame/Relationship (et L. Wil	Type.Print) nters / Wi	1	_				Route Number, Burnie				
	20a. Method of Dis	•		20b. Place	of Dispositi	ion (Name of tory or other pla	100)	Dat	e 2	0c. Lo	cation - City or	Town, State)
		☐ Cremation 3 ☐ 5 ☐ Other (Special	Removal from State (y)			. Cemete		larch	17, 200	9	Brook.	Lvn. M	D
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral 8												
	M01121 Services PA, 1 2nd Ave SW, Glen Bur												
	23a. Part 1. Enter the disease, or compley from that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												nate Between nd Death
	Immediate Cause (Final disease or condition resulting in death) a. We ta Static Lung Cancer												nths
	reconning in death)		Due to (or as	a consequence	e of):	0							
er	Sequentially list con	nditions,	b. Due to for as	a consequence	e offi:					_			
m:	cause. Enter Under Cause (Disease or that initiated events	erlying											
Exa	resulting in death)		Due to (or as	a consequence	e of):	_			<u> </u>				
lical			d										
Mec	IF FEMALE:		00-16							T			
ian/	23b. Was deceden in the past 12	months?	23c. If yes, outcome	2 Fetal dea		ctopic pregnan	су			2	3d. Date of de Month	elivery Day	Year
ysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown		4 ☐ Pregnant a 9 ☐ Unknown	t time of death	5 LL C	other (specify) _						,	
Ph	Part II. Other signit	ficant conditions	contributing to death b	ut not resulting	in the unde	erlying cause gi	ven in Part I	l.	23e. Did toba	acco us	se contribute t	o the cause	of death?
Due to (or as a consequence of): Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										robably 4	Unknown		
plet	Corpora	ry Arte	ry Disec	ise					24a. Was an		24b. Were a	utopsy findin	gs available
E O			1						autopsy perform 1 Tyes 2	ed? No	24b. Were a prior to death?	completion of s 2 □ No	of cause of
Be	25. Was case refer	red to medical					26. Place	e of Death (Check only one			2 2 3 10	
	examiner? 1 ☐ Yes 2 ☑	No	Hospital: 1 ☐ Inpatie	ent 2 ER/C	Outpatient	3 □ DOA Ot	ner: 4 🗆 Ni	ursing Home	5 ☑ Resider	nce 6	Other (Spe	ecify)	
<u> </u>	27. Manner of Deat	h 5 Pending	28a. Date of Inju (Month, Da	ry 28b.	Time of Injury	28c. Inju			d. Describe how				
äţį	2 Accident	investigation	n				lYes 2□	No					
Sertific	3 ☐ Suicide 4 ☐ Homicide	6 Could not b		ury - At home, to. (Specify)	farm, street	, factory, office		281	f. Location (Stre City or Town,		Number or R	ural Route N	umber,
edical Certification: To	29a. Certifier (Check only one)	1 Certifying Pt	nysician: To the best niner: On the basis o and manner sta	f examination a	ge, death o and/or inves	ccurred at the t stigation, in my	ime, date a opinion, dea	nd place, an ath occurred	d due to the ca at the time, da	use(s) te and	and manner a place, and du	s stated. e to the caus	e(s)
ā l			a manner ou										

Registrar DHMH 17 Rev 1/2001

State

29b. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOY

Edwin

P

MAR 17 2009

31. Date filed (Month, Day, Year)

e Colodonato

29c. License number

Basadena

29d. Date signed (Month, Day, Year)

2/122

kenneth W	varrer		1- For State Registrar			land / [Department Certificate		nd Mer	ntal Hygien		. No. 2009 (08340	
Ph Medical E	ysici: xami		1. Decedent's Name					· ·	,	Mont	of Death	Day Year	3. Time of Death 1537 hrs	
)	-Adiiii		Kenneth 4a. Facility Name (i			number)		4b. City, Town,	or Location		h 12, 2	4c. County of De		
			Johns Hopk	ins Bayvie	w Medical Ce	nter		Baltimore						
	neral ector		5. Social Security N		6. Sex	1	In yrs. last birthday) 45	If Under 1 You Months Da	ear If Und ays Hour	e Min	e of Birth	For	Birthplace (State or reign Country) MD	
	ny		Usual Residence of 10a. State	Decedent 10b. County		10	c. City, Town or Loc	ation					10d. Inside City Limits	
pu	28a-f show any Lat once	Ŀ	MD	Balti	more	l	Dunda1k						1 X Yes 2 No	
Maryla	28a-f	ecto	10e. Street and Nur		· ·	<u> </u>		10f. Zip Code	_		10g	. Citizen of What C	ountry?	
h the !	3a or lotifie	ä	3110 Wal	1ford				212	22			USA		
215-0036 be filed within 72 hours after death with the Maryland mral Hoviene	or items 23a or 28a-f sho must be notified at once	Funeral Director	11. Marital Status 1 X Never Marrie	ed 2 Ma	12. Was D Armed	Forces?	lf lf	Vas Decedent of H Yes, specify Cub				14. Race - An White, etc	nerican Indian, Black,	
fter de			3 Widowed	4 Dive	1 Yes		No 1	Yes 2X N	lo specify.	:		Specify: B	lack	
10urs a	xamir	q pe	15. Decedent's Ed		or Dates: cify only highest gr	ade comple		ent's Usual Occup most of working li			9 1	6b. Kind of Busines	ss/Industry	
36 in 721	han "q dical F	Completed by	Elementary/Seco	ndary (0-12)	College	(1-4 or 5+)		ok	ic. Bo 1401	use remou)		Restaur	ant	
5-00.	d other th	E O	17. Father's Name (First, Middle,	Last)		1 00		18.Mothe	r's Name (First, M	liddle, Ma			
21215-0036 unid be filed within 7	narked other than "natural", event, the Medical Examiner	Be	Robert							ralene S				
MD 12 shc	127 is numatic	٩	19a Informant's Na Connita F Denise Wa		nip (Type, Print) ster ister		19b. Mail 3110 605	ng Address (Stre Wallford Appleton	eet and Nur d Dr, St.,			er, City or Town, Str 1 k MD 2 2 I 2 I 7		
Baltimore, permit. Pages 1 and Department of Heal	If item ther trau		20a. Method of Disp 1 X Burial 2	_	3 Removal	from State	20b. Place of Disp crematory or		emetery,	3/20/20	- 1	20c. Location - City	or Town, State	
Itim it. Pag	ortant y or o		4 Donation 5 21. Signature of Fur	Windsor	Mil, MD uneral Tome									
Ba perm	1.1	I												
Physi	ician dical		Wesley Chavis Jr. per DVR 2007-09 Eastern Ave., Baltimore, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
	iner		Immediate Cause (For condition resulting		a. Gastrointe								Between Onset and Death	
			Sequentially list cor		b. Ruptured		•							
		iner	if any, leading to im cause. Enter Under	mediate rlying Cause	Due to (or as	a consequ	ence of):							
p	sit	Examiner	(Disease or injury the events resulting in o		Due to (or as	a consequ	ence of);							
executed	iysician and burial - transit		UNPENDED		dAMENDED			.						
60, ate be c	hysicia e buria	Medical	IF FEMALE:				of pregnancy		_	_		23d. Date of delive		
687 ertific	e attending phy for use as the l		23b. Was decedent p past 12 months		e 1 Live	birth	2 🔲 F	etal death 3	Ectopic	c pregnancy		Month	Day Year	
30X death o	the atter	ysic	1 Yes 2 N	o 9 Unk	nown Heat	inant at tim h nown	e of 5 (other (Specify)			_			
Tat the	중당		Part II. Other signif	icant conditi	ons contributing	to death bu	it not resulting in the	underlying cause	given in Pa	art I. 23e.	Did toba	cco use contribute	to the cause of death?	
S, P	Se Se	ed by	Hepatitis C						-				obably 4 Unknown	
Records,	has been 2 should	Completed								24a.	Was an autopsy	prior to	autopsy findings available completion of cause of	
Rec	certificate has ector, page 2 s	히		-							yes 2			
/ital	this certifi I director,	e Be	25. Was case referre	_	Hospital:	Inpatient	2 ✓ ER/Outpatier		Other	(Check only one) Nursing Home	5 Re	sidence 6 Oth	ner:	
of \	After th	-1	27. Manner of Death	No	28a. Date	e of Injury	28b. Time of		ury at Work			v injury occurred	<u>. </u>	
ion ttendi		atio	1 Natural 2 Accident	5 Pendi Invest				1	Yes 2	No				
Division of Vital pital or Attending Physician: ours after death.	eral Dire	Certification:	3 Suicide 4 Homicide	6 Could determ	not be		- At home, farm, str	eet, factory, office	building, et		ation (Stre own, State	eet and Number or F e)	Rural Route Number, City	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.	To the Funeral Director: completely filled in by the	edical	orfe) /2 🗸 1	Medical Exan	yslcian: To the be niner:On the basis and manner	of examina	nowledge, death occi ation and/or investig	urred at the time, o	date and pla n, death oc	ace, and due to the curred at the time	e cause(s , date and) and manner as sta d place, and due to	ated. the cause(s)	
	_ 3	Ž	29b. Signature and t	itle of certifier	11.5	1			se number		- 1	9d. Date signed (M		
		1	O North as	for	ery)	(ham CC.)	0.0	.M.E.		١,	March 13, 2009	, 	
			80. Name and addre	MD. As	sistant Medic	al Exami	iner 111 Pen	n Street, Balti	more, M	D 21201				
R	Sta egist	ate rar	31. Date filed (Month	JUL*2	2 2009 32. 6	terstrar's S		harry						

DHMH 17 Rev 1/2001 OCME 2006

				For State Registrar		State o	f Mar	yland	-	artmer <i>rtificat</i>				lental Hy	/gieno Reg. No	e . 20	09	08	341
		Physici /Medio		1. Decedent's Name (F Jerome	irst, Middle, Last, Hamiltor		s							2. Date of De Month March	eath 15	ay 20	Year 09	3. Time of 9:40	
		Examir			aris Ho	street and nu Spice	mber)			1	Luth	Location ervil	lle				timor		
		Funeral Director		5. Social Security Numb 215-42-781	5 15	x 7 M 2□F	7. Age (In yrs. la	ast birthday Yrs.	Months	1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, D 8/27/	rth Pay, Year 1943)	Coun	lace (State of try) :h Car	
	Maryland	-f show	tor	Usual Residence of Dec 10a. State 10 MD	b. County Howard	3	1		Town or L		y						1	0d. Inside C	
	with the	23a or 28a st burnuli	Funeral Director	10e. Street and Numbe 336 Oakwes						10f. Zip	Code 210	43				itizen of V	Vhat Coun	try?	
p.m.	-0036 bours after death with the Maryland	perint. Tages I are a should be fined matter to though a tentral requirements and pear perint. I age I talk and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Examine must be ruithed at once.		11. Marital Status 1 □ Never Married 3 🏿 Widowed 4 □		12. Was Dec Armed Fo 1 ☑ Yes If Yes, Gi Year or D	orces? 2 No ive	er in U.S	S. 13.	Was Dece If Yes, spe 1 Yes		ispanic Or an, Mexica Specify		ecify Yes or N Rican, etc.)	0-		e - Americ k, White, e : Bla	etc.	
9:40 p	Maryland 21215-0036	jiene. r than "natur Ire Medical	Completed by	(Specify of Elementary/Secondar 12	Decedent's Edu only highest grad ry (0-12)	cation le completed) College (1-4or 5+)		(Give	edent's Usu e kind of wo DO NOT u Trea	rk done o se retireo	ation during mos I)	st of worki	ng			nmen t	,	
2009	yland y	Mental Hygiarked othe	To Be C	17. Father's Name (First Jack Wat	ts				1			Carm	nella		me				
15, 20	re, Mar	Health and tem 27 is mother traum		19a. Informant's Name Keith Wa 20a. Method of Disposi	tts/ Sor		1	20b. PI	19b. Mail 332 lace of Dispermetery, cre	2 Ca	ra Co	ourt,	E11	icott (Date	City	, MD		3	
MARCH 15,	Baltimore,	artment of sortant: If it in injury or c		1 ☐ Burlal 2 ☐ C 4 ☑ Donation 5 ☐ 21. Signature ■ Funer	remation 3 ☐ F ☐Other (Specify)	· · · · · · · · · · · · · · · · · · ·	State		cony Gi	fts Reg	gistry	7	3/16/2	2009 tomy G				rylan	d
Œ	<u> </u>	Depar Impol		1 50	Set			-						,Ste.P				2107	
•		hysician //Medical xaminer sthe parial-transit	dical Examiner	23a. Part 1. Enter the c shock, or heart fa Immediate Cause (Fin disease or condition resulting in death) Sequentially list conditi if any, leading to imme- cause Finter Underlyin Cause (Disease or inju- that initiated events resulting in death) Last	allure. List only o	a. LIVI Due to b. Due to	each line. ER D] (or as a compare of the compare o	ESEA consequ	Jence of):		o o dyn	g, 50011 ac						Approximat Interval Bet Onset and	ween Death
		nding Ise a	Physician/Med	IF FEMALE: 23b. Was decedent prein the past 12 mo 1 □ Yes 2 □ No 9 □ Unknown	nths?		birth 2	☐ Fetal	death 3	□Ectopic □Other (s	oregnanc	у			×		te of delive	-	Year
- 2	ords, P.O. Bo	en signed build be deta	ed by Pr	Part II. Other significa	nt conditions co	ntributing to d	ieath but i	not resu	ulting in the	underlying o	ause giv	en in Part	l.					ne cause of o	
JEROME	() >	certificate has be ector, page 2 sho	Completed by											per 1 □ Yes	opsy formed? 2 X N		Were auto prior to co death? 1 □ Yes	psy findings mpletion of c 2 □ No	available cause of
	Division of Vital Records	within 24 beyond or decrease. The day within 24 beyond or the day. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To Be	2 Accident		28a. Date (Mor	of Injury oth, Day, \	Year)	ER/Outpation 28b. Time Injury ome, farm, s	of M	28c. Injur Worl 1 □	er: 4□N	lursing Ho	n (Check only me 5 ☐ Res 28d. Describe 28f. Location City or To	how inju	ary occurr	red		
	Hospital	nin 24 hours at the Funeral	edical	one) X Nur	Certifying Phy Medical Exam Se Pract	iner: On the I	basis of e	xaminat	wledge, dea tion and/or	investigatio	n, in my c	ppinion, de	and place, eath occur	and due to th	e, date a	nd place,	and due to	the cause(s)
1	į	Nith Com	Ž	29b. Signature and title	crother	Ma	holl	and	O CR	UP	c. Licens	e number	146	961				Day, Year)	
7		√ Sta		SR. DOROT 31. Date filed (Month, and a second seco	HEA MAH(Day, Year)	LLAND,		P :	2300		EY VA	ALLEY	RD.	TIMON	ILUM	, MD	2109	3	

DHMH 17 Rev 1/2001

			For State	State of M	laryland / Dep	artment of I		d Mental Hy	0	200 0001	,
			Registrar 1. Decedent's Name (First, Middle	e, Last)		Timeate or	Death	2. Date of De	Reg. No.	3. Time of Death	1
п	Physici		David	Jur	nior	Whit	field	Month MARC	Day 14	2009 03:33 P	М
200	/Medio		4a. Facility Name (If not institution			4b. City, Town, o			4c. County of Death		
No. of Street, or other			SINAL HOSPITA.	L OF BAL	TIMORE	BALTIMO		174			
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last birthday	If Under 1 Year Months Days		Min. 8. Date of Bi (Month, D	rth ay, Year)	Birthplace (State or Fore Country)	ign
	Director		219-40-4081 Usual Residence of Decedent	.X 22.	65 Yrs.			02 2.	L 44	, NC	
	land ow		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limi	ts
	Mary a-f sh	tor	MD NA		Balti	nore				1 May Yes 2 □ N	10
	or 28)ire	10e. Street and Number			10f. Zip Code			0	What Country?	_
	23a	ral	3611 Langreh	Road		2.	L244		U.	.S.A.	
	er deg	Funeral Director	11. Marital Status	12. Was Deceden Armed Forces	?	Was Decedent of I If Yes, specify Cub	Hispanic Origin' an, Mexican, Pi	? (Specity Yes or No uerto Rican, etc.)	o- 14. Ra Bla	ice - American Indian, ack, White, etc.	
36	rs aft	by F	1 ☐ Never Married 2X Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 □Yes X□ If Yes, Give Year or Dates:		1 ☐Yes 2X No	Specify:		Speci	fy: Black	
21215-0036	2 hou	Completed	15. Decedent	's Education	16a, Dece	dent's Usual Occup	pation		16b. Kind of E	Business/Industry	_
21	thin 7 ie. ian "r	ng l	(Specify only highes Elementary/Secondary (0-12)	College (1-4or	5+1	kind of work done DO NOT use retire		working		_	
21	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be rofflied at		9th grade	na	P.	lant Mar				ess Company	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaruine must be notified at once.	Be	17. Father's Name (First, Middle,					Name (First, Middle la Will:		me)	
Z.	hould nd Me mark matic	유	Theodore R. 1		10h Mail	na Addraes (Straat		r Rural Route Numb		State Zin Code)	
Ma	nd 2 s ulth ar 27 is rtrau		Joann Whitfi							Md 21244	
Ē,	s 1 ar		20a. Method of Disposition		20b. Place of Disponentery, cre	osition (Name of	20)	Date	20c. Location	- City or Town, State	
Ë	Page:		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		King Me		i	/10/00	. Foot	lawn, Md	
Baltimore,	permit. Departn Importa any inju		21. Signature of Funeral Service	_icensee /	King He	2. Name and Address F/F	ess of Facility	/13/03	wood.	Lawii) Mu	
<u> </u>	89 = 89		Alrome A	: Thompse	\sim $\frac{1}{4}$	300 Waba	sh Av	e, Balt:	imore,	Md 21215	
			23a. Part / Inter the disease, or shock or heart failure. List	complications that cause only one cause on each	ed the death. Do not en line.	ter the mode of dyi	ng, such as car	diac or respiratory	arrest,	Approximate Interval Between	
The same of	Physician		Immediate Cause (Final disease or condition	a.		SEPS	15			Onset and Death	ک
1	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of):		10 C A 1	AICT	e4 c =		
		声	Sequentially list conditions,		IND-STA	It Rt	1071	DISTI	756		
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		ON-ST-	SEGME	NT M	YOCARDIA	AL INFAE	CTION	
ó	an an rial-tra		resulting in death) Last		s a consequence of):					`	_
8760,	icate be executed physician and the burial-transit	dical		d							
		Med	IF FEMALE:								
Вох	eath certific attending p for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	☐ Ectopic pregnand	у			ate of delivery onth Day Year	
0	he de the s	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant 9 ☐ Unknown	at time of death 5	Other (specify) _				oner bay roar	
P.O.	res that the de signed by the be detached		Part II. Other significant condition	ns contributing to death	but not resulting in the u	nderlying cause giv	ren in Part I.	23e. Did	tobacco use cor	tribute to the cause of death?	_
of Vital Records,	puires n sigr Ild be	Completed by	TYPE 2 L	JABETE.	S MELL	1745		1 🗆	Yes 2 No	3 Probably 4 Unknow	۷n
000	w requir s been s should	lete						24a. Was	an 24h	Were autopsy findings availab	le.
æ	The lav	mo						— auto perfo	psy ormed?	prior to completion of cause of death?	
ta	sician; Th certificate rector, pag	Be C	25. Was case referred to medical	1/==			26. Place of I	1 ☐ Yes Death (Check only)		1 ☐ Yes 2 DMo	
Į (Physic this ce al direc		examiner? 1 ☐ Yes 2 ☑ No	Hospital: 12 Inpat	ient 2 ☐ ER/Outpatie	nt 3 DOA Oth	ier: 4 □ Nursin	ng Home 5 ☐ Resi	idence 6 □Ot	her (Specify)	
u o	ding Pt h. After th funeral	ä	27. Manner of Death 1 ★Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury 28b. Time o	Wor	ry at k?	28d. Describe	how injury occur	red	
sio	tendi leath. tor: ≠ the fu	cati	2 Accident investig	ation		-	Yes 2 □ No				
Division	II or Attendir after death. I Director: Af d in by the fu	Certification: To	4 ☐ Homicide determi	ned 28e. Place of In building, e	jury - At home, farm, st tc. <i>(Specify)</i>	reet, factory, office		28f. Location (City or To	Street and Num wn, State)	ber or Rural Route Number,	
_	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Fueral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier Certifyin	g Physician: To the bes	t of my knowledge, dea	h occurred at the ti	me date and n	lace, and due to the	cause(s) and m	nanner as stated	
	e Ho 1 24 h e Fur eletely	Medical	(Check only 2 Medical I	Examiner: On the basis and manner s	of examination and/or i	vestigation, in my	opinion, death o	occurred at the time,	, date and place,	and due to the cause(s)	
	Vithir to the complete complete the complete	Me	29b. Signature and title of certifier	1 1 -	1	29c. Licens			29d. Date signe	ed (Month, Day, Year)	
			1011	cong	5-	RES	- 000	/ ,	MARCH	1 14,2000	3
7			30. Name and oddress of person	who completed dause of	death (Item 23a) (Type,	Print)					
5				MAITHTE	14. D. SI	NHI H	OSPITA	16 07	BALT	MORE	
	Sta Registr		31. Date filed (Month, Day, Year)	2009 32. regist	rar's Signatur	alle					

DHMH 17 Rev 1/2001

MATIENT KNOWN AS WHITFIELD, DAVID

			For State Registrar	State of M	/laryland		artment of I		nd Mental Hy	giene Z	2009	08343
	Physicia		1. Decedent's Name (First, Middle, L CECELIA WINER	ast)					2. Date of De Month	Day:	Year 7009	3. Time of Death 0600 M
4	/Medic Examin		4a. Facility Name (If not institution, g			TAI	4b. City, Town, o			4c. Co	unty of Death	
	Funeral Director	- 1	SEASONS HOSPICE@ 5. Social Security Number 6. 219–10–3466		HOSPI Age (In yrs. le 95		RANDALLS If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bi	rth	9. Birthp Coun	lace (State or Foreign
with the Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show with hinty or other traumatic event, the Weddoal Evanther must be rediffed at once.	Dire	Usual Residence of Decedent 10a. State			, Town or Lo		.0			n of What Coun	0d. Inside City Limits 1 □ Yes 2 □ No http?
0036	ral", or items 23	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 🂢 Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	6? ≬ No			Hispanic Origin an, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	0- 14.	Race - Americ Black, White, e	
21215-0036	/giene. er than "natu i, the Medica	Completed by	15. Decedent's to (Specify only highest governmentary/Secondary (0-12)	Education rade completed) College (1-4o	r 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	durina most o	-		of Business/Ind	LLS ANTIQUI
land	ental H ked oth	To Be	17. Father's Name (First, Middle, Las JOSEPH	HONIGS	RERG			18. Mother's BESS	s Name <i>(First, Middle</i>	n, Maiden Sur LEE	·	
Mary	alth and M 27 is marl er traumati	Ë.	19a. Informant's Name/Relationship FRED WINER/SON		DENO		ng Address (Street	and Number	or Rural Route Numb	oer, City or To	own, State, Zip	Code)
3altimore, Maryland	rtment of He rtant: If item		20a. Method of Disposition 1	ify)	_ ce	metery, crei . YAKO	sition (Name of natory or other pla V BETH I	SRAEL C	Date 03/15/2009	BALTI		D
Balt	Depa Impo any k		21. Signature of Funeral Service Lice	ensee			2. Name and Address OO REISTI		SOL LEVIN ROAD, PI	SON & KESVIL	BROS.,	INC. 21208
Secuted III	Physician and Medical Example Physician and	ω̈	23a. Part 1. Enter the disease, or corshock, or heart failure. List onlimmediate Cause (Final disease or condition resulting in death) Signature of the cause of the cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a b. Due to (or a c.	line.	ence of):			E FULMON		156/158	Approximate Interval Between Onset and Death
vision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be ex	phy	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Fetal at time of de	death 3[eath 5[Ectopic pregnand Other (specify)				. Date of delive Month	Day Year
ords,	s been signed should be det	ted by	Part II. Other significant conditions	contributing to death	but not resul	ting in the u	nderlying cause gi	en in Part I.		tobacco use d		ne cause of death?
al Rec	certificate has b ector, page 2 sl	Completed				-			1 □ Yes	psy ormed? 2 No	prior to cor death?	psy findings available mpletion of cause of
f Vit	is certificate h director, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	itient 2 🗆 E	ER/Outpatie	nt 3 □ DOA Oth		of Death (Check only sing Home 5 ☐ Res		Other (Specif	w Aspice
÷ 5	Dir	Medical Certification: To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 25 Pending investigati 6 Could not determine	ho I	Day, Year)	28b. Time o Injury me, farm, str	Wor	ryat k? ÌYes 2⊡No				l Route Number,
the Hospital	within 24 hours To the Funeral completely filled	lical C	29a. Certifier (Check only one) Certifying F	Physician: To the bes aminer: On the basis and manner:	of examinat	vledge, deat ion and/or in	h occurred at the t vestigation, in my	ime, date and opinion, death	place, and due to the occurred at the time	cause(s) an , date and pla	id manner as s ace, and due to	tated. the cause(s)
To the	within 3 To the comple	Mec	29b. Signature and title of certifier	. —			29c. Licens	CC2/		29d. Date si	igned (Month,	Day, Year)
			30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print) ith Aven	UG 801	1te 203 B	alhm	Cro M	0 21209
	Sta Registr	ar	31. Date filed (Month, Day, Year)	9 Sentina	strar's Signati	par	W		itezos B			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10:45 A M LaVera Mae Yekstat March 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Harford Four Seasons Assisted Living Bel Air If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🔀 F 219 20 7826 84 July 19,1924 Ohio Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State Harford Bel Air Maryland 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21014 USA 1217 Hickory Brook Ct. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White Specify: 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marion Gates Emma Margaret Kies 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Norman Yekstat (Son) 1217 Hickory Brook Ct. Bel Air, Maryland 21014 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 🖾 Buriah 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gardens 3/19/2009 Baltimore, Maryland 4 Donayon 5 DOther (Specify) ure of 5 heral Service Tontisee ^{22. Name and Address of Facility} Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, filly one cause on each line. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final FELLYONICAL disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No 24a. Was an autopsy performe 2 X No 1 □ Yes

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show

7 is marked other than "natural", or items traumatic event, the Medical Examiner my

Department of Health Important; If item 27 any injury or other tropics.

27

2 should be fill and Mental H is marked otl

Pages 1

Director

Funeral

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Completed

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Examine

Physician/Medical

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Certification: To

Medical

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

burialattending pl signed by 1 I be detach page 2 certificate this After 1 Hospital or Attending ours after death.

neral Director: /

that the death certificate be executed

Box 68760,

P.O.

Records,

Vital Physician:

Division of

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ XNo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2⊠No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 K Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

State

Registrar

29b. Signature and title of certifique

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANUSHA SINTHARA , 260 GATEWA 32. Pagistrar's Signature

and manner stated.

within 24 hours at To the Funeral D completely filled is

29c. License number

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	ite of Maryland		artmen rtificate			d Mental I	Hygiene Rag. No	HIG	08345
	Physici /Medic		1. Decedent's Name (First, Middle, Last) EURGE		HY:				2. Date of Month	14	2009	3. Time of Death 500 A M
	Examir Funeral Director	er	4a. Facility Name (If not institution, give street a Politic MAC Vallet 5. Social Security Number 6. Sex 1 M M 2	7. Age (In yrs. has	Hon et birthday) Yrs.	4b. City e F If Under Months	rock	On 11-2 If Under 24 Hours	Hrs. 8. Date of (Month			place (State or Foreign
	pu ≱	ŗ	Usual Residence of Decedent 10a. State 10b. County	10c. City, 1	Town or Lo					/ 1914		W York 10d. Inside City Limits
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980	72 hours after death with the Maryland natural", or Items 23a or 28a-f show Jisal Examiret must be notified at	b	1 Never Married 2 Married 1 5	as Decedent Ever in U.S. ned Forces? Tyes 2 [] No es, Give ar or Dates:	İ	Was Deced if Yes, spec 1 Yes 2			? (Specify Yes of uerto Rican, etc.	No-	14. Race - Americ Black, White, Specify: W	
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	ges 1 and 2 sho t of Health and If item 27 Is m or other traum		19a. Informant's Name/Relationship (Type, Pri Phyllis Cohen/ Daught 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Remova	er 20b. Plac		Engl	ewood	d Plac		Annand	or Town, State, Zip ale, VA ocation - City or To	22003
Baltimore,	permit. Pages Department of I Important: If it any injury or o		4 ⊠Donation 5 □ Other (Specify) 21. Signaturer of Funeral Service Acensee			2. Name an	d Address	of Facility		Gifts	over, Ma Registr nover, M	У
3×	Physician		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause immediate Cause (Final disease or condition	s that caused the death. se on each line.						ry arrest,	nover, in	Approximate Interval Between Onset and Death
8760,	Medical Examiner hysician and the burial-transit	dicai Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Oue to (or as a consequent of the consequent of		e Av asc	De te	me ry tr	Dise Dise	ast eas	2	
.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	es, outcome of pregnanc Live birth 2 Fetal de Pregnant at time of deal	eath 3	Ectopic pro					23d. Date of delive Month	ery Day Year
a	v requires that t been signed by should be deta	ρ	Part II. Other significant conditions contribution	ng to death but not resulti	ng in the u	nderlying ca	ause giver	n in Part I.				ne cause of death?
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of	ding Phye h. After this funeral di	atlon: To Be	25. Was case referred to medical examiner? 1	1 Inpatient 2 EF	VOutpatien Bb. Time of Injury		8c. Injury a	4 Nursi	28d. Descr		6 □Other (Specifing occurred	y)
Division	i i te o	Certification:	4 Homicide	. Place of Injury - At hom- building, etc. (Specify)		,			City or	Town, State	,	
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	COL Circulation and Alle of annual circulation	n the basis of examination id manner stated.	n and/or inv	vestigation,	in my opii	nion, death o	occurred at the til	ne, date and	d place, and due to	the cause(s)
)	F ≯ F 8		30. Name and address of person who complete MARY 31. Date filed (Month, Day, Year)	o, CRn ed cause of death (Item 2)	Р За) (Туре,	Print)	211	39=	71 lotecu	lara	3/16 Dri	12059 12#206
1	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 7 2009	32. Registrar's Signatur	bare	FOC	CU.	lle	Ind	20	850	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar MFND#20ccerFH3/3/09, FMW, MCO Certificate of Death Reg. No-1. Decedent's Name (First, Middle, Last Date of Death
 Month 3. Time of Death Day Year **Physician** Juanita E. Alexander 19;50 p^M /Medical 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery

9. Birthplace (State or Foreign
Country)
Alabama Holy Cross Hospotal

5. Social Security Number 6. Sex Silver Spring
If Under 1 Year 1 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, **Funeral** Months Days Hours Min 1 □ M 2 1 F Yrs 66 Director 123-54-9143 Usual Residence of Deceden 8-10-1942 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f shov traumatic event, the Medical Examiner must be notified at 1√2Yes 2□No Directo MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 11505 Narin RD 20902 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or itel 1 Never Married 2 Married 3 Widowed 4 Divorced Baltimore, Maryland 21215-0036 Specify: Black Completed by If Yes, Give Year or Dates: 1 ☐Yes 2X No Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2yrs Day Care Director Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marie Martin ပ Emzy Edward 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any Injury or other trau Franklin D. Alexander/husband 11505 Narin Rd Silver Spring MD 20902 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Rockville, Maryland Montgomery, MD 12 Burial 2 ☐ Cremation 3 ☐ Removal from State 3-6-2009 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Park Lawn Mem. Park 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Marshalls Funeral Home 4217 9th ST NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a Metastatic Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any least enter Underlying cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Peritoneal Carcinomatosis Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Pulmonary Embolism Due to (or as a consequence of) attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 → Unknown 1 ∏Yes 2 ∏ No Completed certificate has the irector, page 2 sl 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2X No 1 □ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2√2 No Certification: To t Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death After 1 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 🗆 No after death Director: , d in by the f 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled in I 24 hours a 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only within 2 the 29b. Signature and title of certifier 2 29c. License number 29d, Date signed (Month, Day, Year) 0056063

State Registrar

31. Date filed (Month, Day, Y

Adaku Onukogu MD

Forest Glen Rd Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 26, 2009 **Physician** 16:20P. M Georgiana Maria Feyie Aboko-Cole /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital 8. Date of Birth 9. Birmpiace Cone, Africa Abril 23,1946 Siema Leone, Africa If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days Months 1 □ M 2 🔀 F 62 577-70-8650 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10a. State 28a-f show Examiner must be notified at 1 □Yes 2X No Silver Spring Maryland Montgomery Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö United States 20903 1200 Oakview Drive items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black 1 □Yes 2X No 'natural", or Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Ing. M. ODGE. Howard University Health Professions Educator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ophelia Smith William Jonathan Aboko-Cole ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1323 T. Street, N.W. Washington, D.C. 20009 Remie Aboko-Cole -Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Rock Creek Cemetery 3/6/2009 Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Bonnard V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Respiratory distress disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pleural effusion Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner Metastatic breast cancer resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by dehydration 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No 24a Was an 1∐Yes 2XINo 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, To the Hospital within 24 hours a To the Funeral C completely filled

Baltimore, Maryland 21215-0036

State Registrar

29b. Signature and title of certifie

Smitha Bhikkaji, M.D. 1500 Forest Glen Road Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) . Registrar's Signature 03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

D064100

29d. Date signed (Month, Day, Year) February 27, 2009

		•	1 - For State Registrar	State of Maryla	and / Depa			Mental Hy	giene Reg. No. 009	08349	
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last ALCA Forge 4a. Facility Name (If not institution, give	Inder so	~ se 6 0	4b. City, Town,	or Location of Deat	2. Date of Dea Month 3	Day Year 200 4c. County of Dec	0300 M	
	Funeral Director		Social Security Number 6. Se		rs. last birthday) 60 Yrs.	If Under 1 Yea Months Day	r If Under 24 Hrs		h 9. Bi	orthplace (State or Foreign Sountry) ashington, DC	
	he Maryland 8a-f show otified at	Director	10a. State 10b. County MD Calver		City, Town or Lo				10g. Citizen of What 0	10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	be filed within 72 hours after death with the Maryland ital Hygiene. dother than "natural", or Itame 23a or 28a-f show of other than "natural", or Itame 23a or 28a-f show event, line Mydical Exam instrumt be notified a	Funeral Dir	10e. Street and Number 6531 Quiet Court 11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	20	0685 Hispanic Origin? (S ban, Mexican, Puer		U.S.A	• nerican Indian,	
-0036	2 hours after atural', or it	þ	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu	1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates:	16a. Dece	1 ☐ Yes 2 ☐ N	o Specify:		Specify:	white s/Industry	
Maryland 21215-0036	filed within 7. Hygiene."nother than "nother	Completed	(Specify only highest grade Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	red)		health ca:	re			
aryland	d 2 should be f th and Mental it if is marked of traumatic eve	To Be	Melvin Costo								
Baltimore, M	ges 1 an t of Heal If item 2 or other		Angela Lynn Blair 20a. Method of Disposition 1 □ Burial 2 ⊕ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify,	Removal from State	b. Place of Dispo cemetery, cre	osition (Name of matory or other p	1	Date	Hill, GA 3 20c. Location - City of Alexandria		
Baltin	permit. Pa Departmen Important: any injury once.		21 Signature of Funeral Service Licens	Lubar	44	2. Name and Add	ress of Facility Range nes Islan	ausch Fu d Rd., P	neral Home ort Republ	, P.A.	
1	Priysician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart tallure. List only composite the condition resulting in death) Sequentially list conditions,	ications that caused the cone cause on each line. Due to (or as a con Due to (or as a con	sequence of):	we or		c or respiratory a	rrest,	Approximate Interval Between Onset and Death	
8760,	cate be executed oblysicien and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a con							
.O. Box 68	The law requires that the death certificat ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ f 4 □ Pregnant at time 9 □ Unknown	Fetal death 3 i	□Ectopic pregnar □ Other (specify)		4	23d. Date of d Month	lelivery Day Year	
cords, P.	w requires that been signed to should be dete	by	Part II. Other significant conditions of	•	resulting in the t	underlying cause	given in Part I.		Yes 2 No 3	Probably 4 Unknown	
Vital Records,	ician: The lav certificate has rector, page 2 :	Be Completed	25. Was case referred to medical examiner?					auto perfo 1 ☐ Yes eath (Check only o	ormed? death 2€ No 1 ☐ Yo	Approximate Interval Between Onset and Death Death Onset and Death Death Onset	
ō	ding Phys	2	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpatie 28b. Time (Injury	of 28c. In			dence 6 Other (S) how injury occurred	Decify)	
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	il Certification:	3 Suicide 6 Could not be determined	building, etc. (Sp	oecify)			City or To	wn, State)		
€.	To the Hospital within 24 hours a To the Funeral completely filled	Medical		iner: On the basis of exar and manner stated.		29c. Lice	y opinion, death occ	curred at the time,	date and place, and d	nth, Day, Year)	
	3 KW		30. Name and address of person who of	completed cause of death		Print) Po	mce Fre	drost	3/1/20 E, NED	20178	
S. Constant	St Regist	ate rar	31. Date filed (Marth, Day, Year)	32. Registrar's S			•				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amended item#10f, WCHD, SLU, 3.3 Certificate of Death

Reg. No. Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 0605 AM RUTHIE 2004 ARIZONA ALLEN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** WICOMICO (ional Medical Cente Dalisbul If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days Months 1 □ M 2 □ X 70 225-48-1331 VIRGINIA AUG.14,1938 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 21 No Director SUSSEX SEAFORD DELAWARE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ·10973 19973 27730 WOODLAND ROAD AMERICA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1∐Yes 2**∏**No Specify: Specify: WHITE Completed by 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HEATING Elementary/Secondary (0-12) College (1-4or 5+) AIR-CONDITIONING BOOKKEEPER-RECEPTIONIST 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be PLASTER ANDREW D. NEWBERRY ROSALEY ဂ္ 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SON DARRELL L. MORGAN LAUREL, DELAWARE 19956 20b. Place of Disposition (Name of ODD FELLOWS 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 3/2/09 SEAFORD, DELAWARE 4 ☐ Donation 5 Qther (Specify) CEMETER 21. Signature of Fundra WATSONSY ATTES FUNERAL HOME, KING STREETS SEAFORD, DE.19973 FRONT હ complications the t caused the de th. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause in each line. 23a Part 1. Enter in disease shoot of heart failure. Immediate Suse (Final disease or condition resulting in death Approximate Interval Between Onset and Death Fallure - Systolic Bysti ongestive 1teer t Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner uence of): that initiated events resulting in death) Last cardon Due to (or as a consequence of): Like Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 ☐ Other (specify) 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rmea? 2 No 1 ☐Yes 2 ☐No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 ∐ Yes 2 🕱 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

requires that the death certificate be executed sician and burial-tran Box 68760. physician s the burial attending phase as the o Records, sign be 1as page certificate of Vital Hospital or Attending Physician: : After this certific funeral director, Division death.

Funeral

Director

d other than "natural", or items 23a or 28a-f show event, the Dedical Examinational by nothing at

wental Hygiene.
7.27 is marked other than ".
r traumatic event

Department of Health Important: If item 27 any injury or other to once.

Physician

Examiner

/Medical

1 and 2 should be 1 Health and Mental

Pages 1 ment of F

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu To the within 7

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 E. Carroll St. Salisbury MD. 21801 PRMC. 31. Date filed (Month, Day,

100067738

State Registrar

DHMH 17 Rev 1/2001

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	Physici		1. Decedent's Name (First, I Joseph Byrd	Middle, Last)						F	2. Date of De Month	Da:	5 2009	3. Time of Death 230 a N	И
	/Medio Examir		4a. Facility Name (If not inst	titution, give s	street and number	Lospi	tal	4b City, Tow Ball A	n, or Locatio	11-	ty	7	County of Death		
	Funeral Director		5. Social Security Number 371–32–3931		7. A	ge (<i>in yr</i> s.	last birtho	Months Da			8. Date of Bir (Month, Da -27-19	th Year)	9. Birthp Cour SC	place (State or Foreigntry)	gn
	ryland how		Usual Residence of Decede 10a. State 10b. Co			10c. Cit	y, Town o	Location						0d. Inside City Limit	
	ne Ma 8a-fs	ecto	MD P	G		Col1	ege							1XIYes 2 □ No	0
	th with the 23a or 2	Funeral Director	10e. Street and Number 9808 49th Av	enue				10f. Zip Co	^{de} 740			10g. Cit	tizen of What Cour SA	itry?	
1215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examinar Injust be notified at once.	호	11. Marital Status 1. Never Married 24 Dive	Married	12. Was Deceden Armed Forces 1 ∐Yes 2 ⊠ If Yes, Give Year or Dates	?] No	S.	3. Was Decedent If Yes, specify (cify Yes or No ican, etc.))-	14. Race - Americ Black, White, Specify: Bla	etc.	
5-0	72 ho "natu	etec	15. Dec (Specify only I	cedent's Educ highest grade	cation completed)		16a. De	ecedent's Usual O ive kind of work do e. DO NOT use re	ccupation one during m	ost of working	g	16b. K	ind of Business/In	dustry	
2121	d within /giene. er than '	Completed	Elementary/Secondary (0- 9th grade	-12)	College (1-4or	5+)	l	e. DO NOT use re ly Man	etired)			Se	lf Emplo	yed	
Budz	ld be file ental Hy ked oth ic event	To Be (17. Father's Name (First, Mi	iddle, Last)						_	(First, Middle		Surname)		
Ah	h and M r is mar raumat	-	Allen Byrd 19a. Informant's Name/Rela		•				reet and Nun	nber or Rural		er, City o	or Town, State, Zip	Code)	
18, e	t Healt F Healt tem 27	1	Ponise Tatur 20a. Method of Disposition	m/sist	er	20b. F	Place of Di	3 49th An sposition (Name o	f	llege Da		D 20 20c. Lo)740 ocation - City or To	wn, State	
Baltimore,	Pagestment of tant: If I		1 ☐ Burial 2 🖾 Crema 4 ☐ Donation 5 🗍 Oth		emoval from State	9			mator					ia, VIrgi	ni
Ball	permit Depar Import any In		21. Signature of Funeral Se	May	shal	(22. Name and A 4217 9t1					ral Home 20011		
4	Physician /Medical Examiner	iner	23a. Part T. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. List only or	cations that cause e cause on each buy to (or a	line. Fi Fu (s a consequent	eal uence of):	0	mo.			1	eas-e	Approximate Interval Between Onset and Death	
68760,	ificate be executed g physician and as the burial-transit	edical Examiner	that initiated events resulting in death) Last		Due to (or a	s a consequ	uence of):	WWXEH!	rency	VINC	/S				
P.O. Box	t the death certific by the attending p ached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	nı j	3c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Feta at time of c	l death	3 ☐ Ectopic pregi 5 ☐ Other (specif					23d. Date of delive	ery Day Year	
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J Of	ig Phy ter this neral d	n: To	27. Manner of Death		28a. Date of In	jury	28b. Tim Inju	IIIEIII 3 LI DOA	4 ⊔ Injury at Work?		e 5∐ Resi 3d. Describe		6 ☐Other (Special ry occurred	y)	
Division of Vital Records,	or Atten after deat Director: in by the	Certification:	2 ☐ Accident in 3 ☐ Suicide 6 ☐ C	ending nvestigation could not be etermined	28e. Place of II		ome, farm		1 ☐ Yes 2		Bf. Location (City or To	Street ar wn, State	nd Number or Rura e)	al Route Number,	
	Hospital	Medical C				of examina							s) and manner as s d place, and due to		
	To the within 2 To the comple	Me	29b. Signature and title of co	ertifier	in 19.	N	10	29c. Li	sense numbe	36		29d. Da	te signed (Month,	Day, Year)	
	'		30. Name and address of pe	erson who co	mpleted cause of	death (Iten	n 23a) (Ty	pe, Print) Ryland	GIT	ene sai	1 Lo	SOTT	tal		
	Sta Registr		31. Date filed (Month, Day,	Year) 3 200	32 Regis	trar's Signa	iture	and	<u> </u>	MM	, , ,				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Day 2009 Year A M **Physician** 7:12 Catherine Bernadette Bond March 4 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington County Hagerstown Golden Livingcenter Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🛣 F 179-01-5720 90 June 14,1918 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Maryland Washington County Hagerstown Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21740 750 Dual Highway U.S.A. **Funeral** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Agent Real Estate Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Umsted John G. Umsted 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra once. 53 Eagles Trail Fairfield, PA 17320 Michael Joyce-son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buria! 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory 3-5-2009 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 Kaitl 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death diseesse altell coronau Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) Physician/Medical Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🖾 No 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has lirector, page 2 s autopsy performed' 1 ☐ Yes 2 ☐ No 1 2 🔀 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one director To Be Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident death. within 24 hours after death

To the Funeral Director: completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MO 314/05 D66116 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21740 MD 368 MILL STREET Heyerstown 3H-2 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 6 **200**9 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 08353 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 **Physician** 26 Day Gerald Bergman 2009 11:20 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12717 Whisper Trace Ocean City Worcester 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) 5/4/1935 If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days 1**X** M 2□ F Hours 052-28-4578 Director 74 NY Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

nt: If Nem 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar trausat be notified at Director 1 ☐ Yes 2√ ☐ No MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12717 Whisper Trace 21842 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 2 1 ☐Yes 2 ☑ No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Pipe Sales and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Isidore Bergman Ida Goldman မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sid Bergman / brother 2100 Linwood Ave., Fort Lee, NJ 07024 permit. Pages 1 and Department of Healt Important: If Item 2 any Injury or other Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 💢 Burial 2 ☐ Cremation 3 ☐ Removal from State Beth Moses Cemetery 3/1/2009 4 ☐ Donation 5 ☐ Other (Specify) Pinelawn, NY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Pa 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Onset and Death Immediate Cause (Final METASTAN Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner THERO SCI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Vear 5 ☐ Other (specify) 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 No certificate 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 \(\overline{X} \) Residence 6 Other (Specify) 1 Yes 2 X No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 No 24 hours after deatl Funeral Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only Medic one) within 2 To the I 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ,un 10324 ET 31. Date filed (Month, Day, Year 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** 2009 5:45AM 03 Gloria Marjorie Brodsky /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbur Dastal HOSPICE Omic If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 1 □ M 2 ■ F Days 213-20-1002 83 6/11/1925 Maryland Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, I'm Modical Evan marginal to modified at 1 ☐ Yes 2 X No Funeral Director Maryland | Wicomico Salisbury 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5920 Tappan Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates 1 ☐ Never Married 2X Married 1 ☐Yes 2 No Specify Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Country Club Bookkeeper and 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental F Harry Diamond Evelyn Arenson ၉ Jon & Baltimore, Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 5920 Tappan Lane Salisbury, Maryland 21801 Arnold Brodsky/husband Department of Healt Important: If Item 2 any injury or other once. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date Druid Ridge Cemetery 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 3/2/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Holloway Funeral Home P.A. 21. Signature of Euneral Service Licenses 501 Snow Hill Rd. Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final BND 5 TACIZ DRUBNTIA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physician; The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 No 9 Unknown 9 Unknowh Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 24H0 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No of Other (Specify) HOSPICA 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Miln er of D ath 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) |
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated To the I within 2 29b. Signature and title of certifier 0005 8410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOX 1733 Huutin WAMS COASTHE HOSPICIZ 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Registrar

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Division of Vital Records, P.O. Box 68760 within 24 hours a To the Funeral

Registrar

DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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none

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mn

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

mo

3-10-09

Dive Set 203 Cumberland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 27, 2009 8:15 P^{M} February Thomas Joshua Cooper 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Montgomery Rockville Casey House If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 5 Social Security Number Min. Months Days Hours 067-38-6178 1 1 M 2 □ F 12/08/1943 65 Massachusetts Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County Alexandria 1X Yes 2 No Virginia 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 22314 314 N. Saint Asaph Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Venable LLP. / Law Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rena Mae McIntosh Joshua W. Cooper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sara Cooper Masterson / Sister 101-Pommander Walk Alexandria, Va 22314 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 Crematory 3 /2/09 Falls Church, Va 22. Name and Address of Facility Joseph Gawler's Sons Inc. 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 10 Years Metastatic Colon Cancer Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Ye ar 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 XUnknown

Physician /Medical **Examiner**

Physician

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyghene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must 300ce.

Baltimore, Maryland 21215-0036

Director

Funeral

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Hospital or Attending Physician: The law requires that the death certificate be executed physiclan and s the burial-trans 宇 cate has been signed by page 2 should be detach this After t after death Director: /

Division of Vital Records, P.O. Box 68760,

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: ${}_{4}\square$ Nursing Home ${}_{5}\square$ Residence ${}_{6}X$ Other (Specify) Hospice 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and

To the I within 2

e Funeral I

Registrar

State

umana 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L. Puthumana MD. 31. Date filed (Month, Day, Year)

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February 28, 2009

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			For State Registrar	State of Marylan		rtificate of i			g. No.	
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	Physicia /Medic				KE, J			FEB. 2	3, 2009	4:47 A ^M
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anger of the			5. Social Security Number 6. Sex			If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		irthplace (State or Foreign
	Funeral Director			IM 2□F 50	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Aug. 3,	1958 L	iberia
	ס		Usual Residence of Decedent	10-0	T					10d. Inside City Limits
	arylar show	ŗ	10a. State 10b. County MD Montgor		ty, Town or Lo	antown				1 Yes 2 □ No
	the M	recto	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
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	death	Funeral Director	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. \	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Ar Black, Wh	nerican Indian,
92	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, it is McJical Expring must be notified a		1 ☐ Never Married 2 【X Married	1 ⊟Yes 2 No If Yes, Give		i∐Yes 2∐KNo		,		3lack
Ö	hours tural",	Completed by	3 Widowed 4 Divorced	Year or Dates:	16a Decer	dent's Usual Occup	nation	1	6b. Kind of Busines	
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Baltimore, Maryland 21215-0036			19a. Informant's Name/Relationship (Ty) Katherine P. Cla			•	and Number or Rui			
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≣	permit. Pages 1 and 2 Department of Health a Important; If item 27 is any injury or other tra once.		21. Signau re f Funeral Service Licens		1 22	2. Name and Addre	ess of Facility SN(OWDEN FI	UNERAL E	HOME, P.A.
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			23a. Part 1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the dea ne cause on each line.	th. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
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Box	eath certific attending p for use as	Physician/M	in the past 12 months?	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	al death 3	☐ Ectopic pregnand ☐ Other (specify) _	су		23d. Date of Month	Day Year
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ν, σ	or Attending Physician: The law requires that the death cert ifter death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use.	by Pr	Part II. Other significant conditions con	ntributing to death but not re	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did tob	acco use contribute	e to the cause of death?
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Division of Vital Records,	ician: Sertific ector,	Be (25. Was case referred to medical examiner?	Hospital:		Ott	201	th (Check only one		
of	Phys this ral dir	<u>۲.</u>	1 ☐ Yes 2 ☐ No ☐ 27. Manner of Death	28a. Date of Injury	ER/Outpatie	III SU DOA	4 Li Nursing In	ome 5 Reside 28d. Describe ho	nce 6 Other (S	pecify)
on	iding th. After	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	Wo	rḱ?]Yes 2∐No		,,	
/isi	Atten r deal ector: by the	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At I	nome, farm, sti	reet, factory, office		28f. Location (Str. City or Town		Rural Route Number,
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	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licen			9d. Date signed (Mo	
			CA Signature and the of vertiller	Omes MAI)		06299		16 23	2009
	3(3)		30. Name and address of person who co	ompleted cause of death (Its	m 23a) (Type		, , , , ,	1 1		
			Petek Donmez,				ike, #40	Ol, Rocl	kville,	4D 20852
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Registrar

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-4	/Medic		Melvin Gilbert C 4a. Facility Name (If not institution, give				4h City Town o	r Location of Death	Februar		County of Death	10:10 A ^M
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	Funeral		5. Social Security Number 6. Security Number 11	ex 7. Ag	e (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	rth	9. Birthp	lace (State or Foreign
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	P .		Usual Residence of Decedent									
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	er de item	Ë	11. Marital Status 1 ☐ Never Married 2 ፟ Married	12. Was Decedent Armed Forces?		5. 13. 13.	If Yes, specify Cub	lispanic Orlgin? (Sp an, Mexican, Puerto	Rican, etc.)	0-	 Race - Americ Black, White, or 	
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Mar	2 sho		19a. Informant's Name/Relationship (7			1 .		and Number or Ru			•	Code)
رب ح	and lealth m 27 her to		Catherine S. Cat1	ett / Spo				Court Bet				04-4-
Ö	ges 1 It of F If ite or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	200. P	emetery, crer	sition (Name of natory or other plac	ce) 0.2 / 0.1	Date 2/2009		cation - City or To	
	t. Partmen tant: njury		4 □ Donation 5 □ Other (Specify		Gat		leaven Ce	met.			er Sprin	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other traumatic enone.		21. Signature of Funeral Service Licen	see				ess of Facility Jos				
	20 = 10 G	\dashv	23a. Part 1. Enter the disease, or comp	- All	1 41 41-			nsin Ave			ton, DC	20016 Approximate
			shock, or heart failure. List only	one d ause on each li	ne.	. Do not eni	er the mode of ayl	ng, such as cardiac	or respiratory a	arrest,		Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Sepsis								
	Examiner		1	Due to (or as			de (Seco	ndary to	Δ)			
		P.	Sequentially list conditions,	b. Due to (or as			as (beec	ildary co	11/			
0	Insit	Examiner	Sequentially list conditions, if any, leading to immodate cause. Enter Underlying Cause (Disease or injury that initiated events	Respir			ıre					
<u>.</u>	be executed sician and burial-transit	Exa	resulting in death) Last	Due to (or as	a consequ	ence of):			· · · · · ·			
60,	e be rsicia e buri	cal		Valvul	ar Di	sease	(Heart)					
8	eath certificate be executed attending physician and for use as the burial-transit											
X R R	h cer endin use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			☐ Ectopic pregnanc			1 :	23d. Date of delive	ery
	death te atten	i Si Si Si	in the past 12 months? 1 □Yes 2 □ No	4☐ Pregnant a			Other (specify)	·y			Month	Day Year
7. O	that the dended by the detached	Physician/Med	9 Unknown									
	es that igned b	by	Part II. Other significant conditions of	ontributing to death b	ut not resu	ılting in the u	nderlying cause giv	en in Part I.				he cause of death?
ecords,	w requires to see a signal should be	pe				****			1 🗆	Yes 2[TxNo 3 ☐ Prob	pably 4 ☐ Unknown
ပ္ပ	law r as be 2 sh	ble							24a. Was	DSV	24b. Were auto	psy findings available mpletion of cause of
r	The late has page	Completed							perfe 1 □ Yes	ormed? 2] [No	death? 1 ☐ Yes	
Ig	sician: The law certificate has t irector, page 2 s	Be (25. Was case referred to medical examiner?					26. Place of Dea	th (Check only			
o 	Attending Physician: r death ector: After this certification by the funeral director, p		1 Types 2 □ No				nt 3 □ DOA Oth	4 Li Nuising ii	ome 5 Res	idence (6 □Other (Specif	(y)
	fter there	ü.	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	ıry ay, Year)	28b. Time o Injury	Wor	k?	28d. Describe	how injur	y occurred	
<u> </u>	teath tor: / the f	cat	2 Accident investigation 3 Suicide 6 Could not be					Yes 2 No	006 1	(0)		- CD
UIVISION	after death after death Director: d in by the f	Certification: To	4 Homicide determined	28e. Place of Inj building, el	c. (Specify	me, rarm, str /)	eet, factory, office		City or To	wn, State	d Number or Rura)	u noute ivumber,
	oita urs eral		29a. Certifier 1 Certifying Ph	ysician: To the best	of my know	wledne deat	h occurred at the ti	ime date and place	and due to the	a cause/e	and manner as	stated.
	To the Hospital or, within 24 hours after To the Funeral Direct completely filled in the funeral or the funeral filled in the funera	Medical		niner: On the basis of and manner st	of examinat							
	o the	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. Dat	te signed (Month,	Day, Year)
	->-0	- 1	1 de 1 -	SUDANG	1441	CIA		15212		- 1	1/24	

10 State

Sudarshan Siva MD,8600 Old Georgetown Rd. Bethesda, MD 20814 31. Date filed (Month, Day, Year) MAR 03 2009

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** March 2009 Pamela Elaine Clipp /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 09/08/1957 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Hours 1 □ M 2**X** F Months Days 213-72-8030 51 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be restlised at 1 ☐ Yes 25 No MD Washington Hagerstown Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21740 US 12120 Hopewell Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 11. Marital Status 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12Vice President Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evone. Mary Virginia Kline John Raymond Kershner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19515 Portsmouth Dr, Hagerstown, MD 21742 Brian K. Gouff / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/09/2009 Hagerstown, MD Rose Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 6 Mo **Physician** disease or condition resulting in death) Lavge cell neuro endocijna /Medical bong metastasis Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

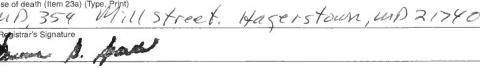
To the Funeral Director: After this certificate has been signed by the attending physiciar completely filled in by the funeral director, page 2 should be detached for use as the burit Physician/Medical IF FEMALE: 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) 1 ☐ Yes 2 🗷 No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Harring Sees 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

E. Woned



WID 359

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 08360 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** Patsy Leah Callaway 2 5:52 A 28 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death ⊱- Examiner 619 William St. Berlin Worcester 8. Date of Birth (Month, Day, Year) 2/28/1947 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. 1 □ M 2 🛛 F Months Days Hours 62 221-28-7462 DE Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov ury or other traumatic event, It is Medical Examination at the modified at 1 ☐ Yes 2 X No Director MD Berlin Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 619 William St. 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No If Yes, Give Ye ar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: Completed by Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Caregiver Health Care 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ira Donaway, Sr. Elizabeth Rogers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and:
Department of Health
Important: If Item 27
any injury or other tr.
once. Alan Callaway / husband 619 William St., Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/4/2009 Riverside Cemetery 4 Donation 5 Dother (Specify) Berlin, MD 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 21. Signature of Fundal Service Licensee turol 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LETRUCTIVE Yumonery **Physician** hamic years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 1 ☐ Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Monch 2, 2009 D30619 June (30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abbett 18445 Ocean Cory Blod 1:XERIN MD 21811 31. Date filed (Month, Day, Registrar's Signatur State MAR 03 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-01896 2009 08361 State of Maryland / Department of Health and Mental Hygiene John Russell Drinks, Sr. Certificate of Death 1- For State Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day March 6, 2009 2220 hrs **Medical Examiner** Russell Drinks. Sr. John c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Calvert northbound Route 4 at Plum Point Road Huntingtown If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 7. Age (In yrs. last birthday) 6 Sex 5. Social Security Number Foreign Country)Wash. DC **Funeral** Hours Months Davs 02-25-1963 Director 46 216-82-8400 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location iny 10a. State 10h County 1 Yes 2 X No s 23a or 28a-f show a notified at once. Huntingtown Calvert MD after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20639 1260 Plum Point Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11 Marital Status White, etc. Armed Forces 1 Never Married 2 X Married <u>.</u> white Specify: Yes 2 X No specify: f Yes, Give Year Divorced 1987 3 Widowed event, the Me ical Examiner "natural", 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 hours nit. Pages 1 and 2 should be filed within 72 hour tranent of Health and Mental Hygiene. Completed Elementary/Secondary (0-12) College (1-4 or 5+) Union Journeyman Carpenter construction 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Yvonne Tayman Barbara Be Edward Drinks. Charles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Davenport, FL 33837 561 Par Pines Blvd., Charles E. Drinks, Jr., father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date Baltimore, N permit. Pages 1 and Department of Healti Important: If iteni injury or other trav 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 3/12/2009 Alexandria, VA Donation 5 Other Specify: 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licenses 8325 Mt. Harmony Lane, Owings, MD 20736 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and Death Medical Multiple injuries Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit death certificate be executed AMENDED 23a,27,28a-f,perME,g891 5/12/09 TT Physician/Medical X UNPENDED attending physician or use as the burial -23d. Date of delivery Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown a Unknown 23e. Did tobacco use contribute to the cause of death? requires that the contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? certificate has 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) ospital or Attending Physician: hours after death. 25. Was case referred to medical of Vital Be examiner? Hospital: 1 Residence 6 V Other: Scene Nursing Home 5 ER/Outpatient 3 Inpatient 2 After this 1 🗸 Yes 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred **pedestrian stepped in front** 27. Manner of Death Certification: Yes 2X No Natural Division Pending of a car Director: d in by the f 3/6/2009 10:20 pm Accident Investigation 28f. Location (Street and Number or Rural Boute Number, City or Town, State) NB Rt. 4 @ Plum Point Rd Huntingtown, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3X Suicide Could not be To the Funeral Di determined roadway Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 7, 2009 O.C.M.E. Monte 30. Name and address of person who completed cause of death (Item 23a)

State Registrar Margarita Korell MD.

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

			State of Maryland / Dep State Amend Items 23aPtI,26,28a-f pere	artment of Health and The 889 03/30/090 Thineate of Death	ihb	eg. No. 2009	08362
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	/Medic		William Eugene Davis, Sr.	the City Towns and another of Do	March	4 2009 4c. County of Dea	
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	atri	Washingto	
AT.	Funeral		1030 Pennsylvania Ave. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		n (Month, Day	9. Bir	thplace (State or Foreign ountry)
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	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
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	er de	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	erto Rican, etc.)	14. Race - Am Black, Whit	te, etc.
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d 2	2 should be filed w n and Mental Hygie 'is marked other t raumatic event, III	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's N	ame (First, Middle,	Maiden Surname)	
Maryland	should be f and Mental is marked of aumatic eve	To B	Luther Daniel Davis			oaker Davis	
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Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev once.			22. Name and Address of Facility D			
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			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	4		rest,	Approximate Interval Between Onset and Death
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	/Medical Examiner		Due to (or as a consequence or):	J	174		
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Box	leath certif attending for use as	ľ.	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3	☐ Ectopic pregnancy		23d. Date of de	
O. B	ed for	Physician/M	In the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5	Other (specify)		Month	Day Year
<u>~</u>	ires that the de signed by the a l be detached f		9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
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<u> </u>	The la ate ha	mo:			autop perfor1 □Yes	med? death?	s 2 No
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d	Physi this c	ပ္	examiner? 1 Dres 2 No Hospital: 1 Inpatient 2 ER/Outpati 27. Manner of Death 28a. Date of Injury 28b. Time			lence 6 Other (Sp	_{ecify)} at scene
Division of Vital Records,	th. : After	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury FOUNT TOWN Year) 03/04/2009 28b. Time Injury Unknown	Work?		t hanged s	elf.
Visi	er dea rector by the	tifica	3 Noticide 6 Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office	28f. Location (S City or Tow	Street and Number or F rn, State) 1030 P	Rural Route Number, ennsylvania
Ξ	urs aft rai Di		Garage	-th annual of the time date and vi	Avenue,	Hagerstown	,MU
	To the Hospital or Attending Physician: The law requires that the death certil within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	aut occurred at the time, date and pl investigation, in my opinion, death o	ace, and due to the ccurred at the time,	date and place, and du	ue to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor	nth, Day, Year)
			Thomas Gibert Do FACED	H40884		03-06-	2009
01	SH 8		30. Name and address of pelson who completed cause of death (Item 23a) (Typ			017/0	
Ų.	H S Sta	ate.		ietam St., Hager	stown, MD	21740	
	Regist		MAR 0 6 2009	pari			

9-004	91
Daniel	Dunlap

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ei Duillap		1- For State Crivial yland / Bopartiment of Treath	,	Reg. No.	2009 083
Physici		Registrar 1. Decedent's Name (First, Middle,Last)		Date of Death Month Day	3. Time of Death 0845 hrs
dical Exam	iner		n, or Location of Death	January 17, 200	County of Death
		4a. Facility Name (if not institution, give street and number) 4b. City, Town 6811 Old Alexander Ferry Road Clinton			Prince George's
		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1	Year If Under 24Hrs.	8. Date of Birth (MM)	/DD/YYYY) 9. Birthplace (State or Foreign
Funeral Director		212-31-6266 1X M 2 F 23 Yrs. Months	Days Hours Min.	September	Country
		Usual Residence of Decedent		Берцеплет	
any	-	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 Yes 2 X No
and show	b	Virginia West Moreland Colonial Beach		Lang Cit	tizen of What Country?
Marylis 28a-f d at o	Director	10e. Street and Number 10f. Zip Cod	de	Tog. Cit	
death with the Maryland or items 23a or 28a-f sho must be rotified at once.	Ö	500 Livingstone Street 2244	43 of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - American Indian, Black,
ath wit items	uneral	1 X Never Married 2 Married Armed Forces X Y	Cuban, Mexican, Puerto R	Rican, etc.)	White, etc.
		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X	No specify:		Specify: White
nurs af	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occurrence of working most of working	cupation (Give kind of wo		Kind of Business/Industry
5 72 ho in "no	leted	Elementary/Secondary (0-12) College (1-4 or 5+)			D' 13 1
21215-0036 ould be filed within 7 I Mental Hygicne, marked other than	Comple	10 th. None- Handid	18 Mother's Name	(First, Middle, Maide	Disabled n Surname)
filed Hyg	ပိ		1.00	enise Sant	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygicine. 27 is mairked other than "matural", or items 23a or 28a-f shtemarie event, the Medical Examiner must be motified at our	o Be	Jeffrey Wayne Dunlap 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address ((Street and Number or R	tural Route Number,	City or Town, State, Zip Code)
MD and 2 shot m 27 is	-	Jeffrey Wayne Dunlap/Father 500 Livings	stone St. Co	olonial Be	each VA 22443 C. Location - City or Town, State
ore, MD 21215-003 1 and 2 should be filed vithit of Health and Mental Hygicine, If item 27 is marked other the		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State crematory or other place)	of cemetery,	Date 200	c. Location - City or fown, State
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygisne. Triem 27 is marked other flam "matural"; hours reasonable system; the Medical Examiner.		A Donation 5 Other Specify: Trinity Mem. Ga	ardens Jan	. 24, 2009	9 Waldorf, MD.
Baltimore, permit: Pages 1 ar Department of He Important: If ite	(E = 5) = 1	21. Signature of Funeral Service Licensee 22. Name and Ad	ddress of Facility Hur	ntt Funera	al Home
യ ഉറ⊑:		23a. Part I. Enter the disease, or amplications that caused the death. Do not enter the mode of or	d Washingtor	n Kd. Wald	dorf. MD. 20601 shock, or heart Approximate Interva
Physicia		failure. List only one cause on each line.	2)g, 22 2		Between Onset and Death
amine		Immediate Cause (Final disease or condition resulting in death) a. Oxycodone toxicity Due to (or as a consequence of):			
		Sequentially list conditions, b.			
	ğ				
	Evaminer	(Disease or injury that initiated events resulting in death) Last			
executed an and	75		- 6889 3/18	/09 TT	
760, cate be execut physician and	Modical	X UNPENDED AMENDED 23a, 27, 28a-1, permi	, 600) 3/10		
sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be death. After this certificate has been signed by the attending physici	The par	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregna		23d. Date of delivery Month Day Year
Box 687 ne death certific	tor use as th	past 12 months? Live birth past 12 months? Pregnant at time of death The past 12 months? Other (Specification of the past 1)			
Box death he atte	d for t	<u> </u>		TO BILLIA	co use contribute to the cause of death?
P.O. B. ss that the de	<u>ੁ</u>		ause given in Part I.		2 No 3 Probably 4 Unknown
S, P.C				24a. Was an	24b. Were autopsy findings availab
ords w requi	should			autopsy performed	prior to completion of cause of
Reco	, page 2 should be			1 Y Yes 2	No 1 ✓ Yes 2 No
tal Rection: The certificate	director, page	25. Was case referred to medical	6.Place of Death (Check		sidence 6 V Other; Scene
of Vit ing Physic After this		1 V Yes 2 No	8c. Injury at Work?	28d. Describe how	
ding F	절 .	. 27, Walling of Death	1 Yes 2 X No	unk	
ivisior or Attendafter death	by the	Accident Pending Panding Fd 1/17/09 Fd 8:35 and Investigation 2 28e. Place of Injury - At home, farm, street, factory,	office building, etc.	28f. Location (Stre	eet and Number or Rural Route Number, Ci
: કુકુ	filled in by the	Suicide 6 A Could not be determined (Specify) House		or Town, State Ferry Rd	CLinton, MD
lospit 4 hour			time, date and place, an	d due to the cause(s	and manner as stated.
DIVI To the Hospital or within 24 hours after To the Funeral Dir	completely	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	opinion, death occurred	at the time, date and	place, and due to the cause(s)
7 8 7	8	29b, Signature and title of certifier	, License number	1	9d. Date signed (Month, Day, Year)
		layent me Kull	O.C.M.E.		January 18, 2009
		30. Name and address of person who completed cause of death (Item 23a)	eet, Baltimore, MD	21201	
		Parietraria Signatura			
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		-	For State		State	of Ma	ryland		artmen rtificat			and M	ental Hy		e 2009	(0836	
			Registrar 1. Decedent's Name (First, Mi	ddle, La	st)			Cei	inicai	e oi L	Jeani		2. Date of De		2000		JOJO *	Ŷ
	ysicia		Virginia Fre			n							Month Februar	Da v 27			11:50p h	Λ
_	<i>l</i> ledic amin		4a. Facility Name (If not institu	ition, giv	re street and n	umber)			4b. City,	Town, or	Location o		1 COL COL		. County of Dea	ath	11.50р	_
			2712 Covered Wa	gon 1	<i>V</i> ay					Olne	J			I.	bntgomery	7		
Fun	eral		5. Social Security Number	6. 5	ex □M2XTF	7. Age	(In yrs. la	st birthday)	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth a <i>y, Year)</i>	9. Bi	rthplace ountry)	(State or Foreig	jn.
Dire	ctor	-	577-36-6083 Usual Residence of Decedent			<u> </u>	8	38 Yrs.					April 9		20	VÁ		_
land	**	ŀ	10a. State 10b. Cou	nty			10c. City,	Town or Lo	cation							10d.	Inside City Limit	s
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h the	thous a	Director	10e. Street and Number						10f. Zip	Code				10g. Ci	tizen of What C	ountry?)	_
th wit	d is	al D	2712 Covered Wa	gon 1	Vay					2083	2				US	SA		
Dattilliofe, Infally idition 21213-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show	SEC.03	Funeral	11. Marital Status		12. Was De Armed F	cedent E Forces?	ver in U.S	. 13. \	Vas Deced	dent of Hi	spanic Orig	gin? (Spec	cify Yes or Ne	0-	14. Race - Am Black, Whi		ndian,	
s afte	E E	by Fi	1 Never Married 2 N		If Yes, C	2 ▼N Bive	0		I □Yes	2 💢 No	Specify:				Specify: Wh			
2-0030 72 hours af natural", or	3 5		3 X Widowed 4 ☐ Divorce		Year or	Dates:		16a. Deced	lant'e Heus	al Occupa	ntion			16b K	and of Business	/Indust	rv.	
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2 short and ismal	ranm		19a. Informant's Name/Relation	onship (Type. Print)			19b. Mailin	g Address	(Street a	nd Numbe	r or Rural	Route Numb	er, City	or Town, State,	Zip Co	de)	
t and Health	thert	9-	Carol Emerson 20a. Method of Disposition	/ Dat	ughter_		Took Bis						ey, MD 2		ocation - City or	Taura	Ctata	
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			23a. Part 1. Enter the disease shock, or heart failure. L	or com	plications that	caused t	the death.				_						proximate erval Between	
Physic	ian	1	Immediate Cause (Final disease or condition					langio	carcin	oma						Or	set and Death months	
/Med	_		resulting in death)				conseque		301011	SAI EX						_		
Exami		_	Sequentially list conditions,		b	,												
ted	sit	ie	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹	Due to	o (or as a	conseque	ence of):										
execu	al-tra	Examiner	that initiated events resulting in death) Last		c	o (or as a	conseque	ence of):										_
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rtificat	as th																- 02.0 3.5	
or the center tending	r use	sician/M	IF FEMALE: 23b. Was decedent pregnant	14	23c. If yes, o		of pregnan] Ectopic p	regnancy				(t)	23d. Date of de	-		
e dea	bed fo	sici	in the past 12 months? 1 ☐ Yes 2 XX No		4 ☐ Pre 9 ☐ Uni		time of de		Other (sp					ĺ	Month	Day	/ Year	
hat th	etac	Phy	9 ☐ Unknown Part II. Other significant cond	litione	ontributing to	daath but	t not rocult	ting in the ur	darking o	auso sivo	n in Part I		23e Did	tobacco	use contribute t	o tho c	auco of doath?	П
Attending Physician: The law requires that the death certificate has been signed by the attending	d be	ð	art ii. Other significant cone	inions (ortanodang to	acain bu	t not resum	ang in the ui	idenying d	adse give	ii iii i aici.			Yes 2			4 ☐ Unknow	n
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VILAIF sician: The certificate	or, pa	ပိ	25. Was case referred to medi	cal							00 01	-f D11	1 □ Yes (Check only	2 🛂 No	1 ☐ Ye	2 [No	
ysici	direct	P P	examiner? 1 ☐ Yes 2 ☑ No		Hospital: 1	1 Inpatier	nt 2∏E	R/Outpatien	t 3 🗆 DC	Othe	r·		,		6 ☐Other (Spe	acifu)		_
ding Physician: The In. h. After this certificate h	neral	Ë.	27. Manner of Death 1 ☑ Natural 5 ☐ Pen	din a	28a. Date		y 2	28b. Time of Injury		8c. Injury Work			3d. Describe			,ony,		
endir eath.	he fu	ätic	2 ☐ Accident inve	stigation	1	, =,,		,,	М		es 2 🗆 N	10						
or Att	in by 1	Certification:	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	ermined	28e. Plac	e of Injur ding, etc.	ry - At hom (Specify)	ne, farm, stre	et, factory	, office		28	Bf. Location (City or To	Street ar wn, State	nd Number or R e)	ural Ro	ute Number,	
pital o	lled		29a, Certifier 1X Certif	in Di	walalas. To th	a back of	6 may len nyy	lados deste				d all an a	- 1 1					
To the Hospital or Attendin within 24 hours after death. To the Funeral Director; Aft	letely	edical	(Check only 2 Medic	al Exar	niner: On the	basis of nner stat	examination	on and/or in	estigation	, in my op	inion, deal	d place, a th occurre	d at the time	date an	s) and manner a d place, and due	e to the	cause(s)	
To the To th	comp	-	29b. Signature and file of cert	ifier	1) /	1			290	. License	number			29d. Da	te signed (Mon	th, Day,	Year)	
ID			Mich	lus	Kuch	() 1	mis			D385	509			Marc	h 2, 2009)		
			30. Name and address of pers															
	0, -		Nicholas W. Ko 31. Date filed "Month", Day, Ye.				11 r's Signatu		ttle Pa	atuxer	nt Parl	cway,	Columbi	a, MD	21044			
Re	Stat gistra	٠	MAR 03	0.04				bar	4									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 4:36 p M February 2009 25 Barbara Lee Palis Ellis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Laurel Regional Hospital Laure1 Prince George's Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 □ M 2 🖾 F Yrs. Director 460-26-1625 82 March 24, 1926 Florida Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 K No Directo Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3148 Gracefield Road, Apt. 105 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify: δ 3 ☐ Widowed 4 🖾 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene.

27 is marked other than "r r traumatic event, Inc Med Elementary/Secondary (0-12) College (1-4or 5+) Administrative Aid University of Maryland 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If item 27 is marked oth any linjury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be Elizabeth Cockrill ပ္ Frederick W. Palis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert Ellis - Son 229 Lizzie Mills Road, Castleton, VA 22716 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cemetery: 03/02/2009 Adelphi, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 1. Vloter 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Myocardial Infarction Minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☒ No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by to detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4x Unknown Atherosclerotic Cardiovascular Disease Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Lumbar Radiculopathy has page 2 autopsy performed? certificate l 2 No 1 □ Yes 2 🖸 No 1 ☐ Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 | Pending s after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24035 February 26, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Eugenio S. Machado,

3

31. Date filed (Month, Day, Year)

Registrar's Signature

M.D., 3110 Gracefield Road, Silver Spring, Maryland 20904

/Medical Examiner The law requires that the death certificate be executed the burial-tran Division or Vital Records, P.O. Box 68760 attending physician or Attending Director:

Physician

/Medical

Examiner

Funeral

Director

ral", or Items 23a or 28a-f show Examiner must be notified at

'natural', or

Medical

Director

Funeral

Be

with the Maryland

r death v

filed within 72 hours after Hygiene.

and 2 should be ealth and Mental

is marked

permit. Pages 1 and 2:
Department of Health as Important: If Item 27 is any Injury or other trauonce.

Physician

Baltimore, Maryland 21215-0036

Examine Physician/Medical þ Completed Be Certification: To 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

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completely filled in by

after

To the Hospital within 24 hours at To the Funeral D

D

Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jaleh Dael MD. 9470-Annapoli's Rd. #418 Lambam MD. 20706 32 Registrar's Signature

		-	For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Maryl		rtment of F		Mental Hyo	Reg. No.2 0	09	08367
	Physici /Medic	an	Molly Ellen	Ennis				Month 02	Day 27	o Year	1927 M
*	Examin		4a. Facility Name (If not institution, give s PENINSULA REGIONAL		משיחואי	4b. City, Town, o	r Location of Deat	h		ty of Death	
***	Funeral		5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt		9. Birthp	lace (State or Foreign
Н	Director		424-48-2851 ^{1□}	M 2 XF 74	Yrs.	Months Days	Hours Min.	03/02/	1934	Nort	h Carolina
	and		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Lo	cation				1	0d. Inside City Limits
	Maryl a-f sho	tor	Maryland Wicomic	o s	Salisbury						1⊠Yes 2□No
	or 286	Director	10e. Street and Number		*	10f. Zip Code			10g. Citizen o	f What Cour	itry?
	sath w	eral	300 Locust Terrac	2. Was Decedent Ever	in IIS 13)	2180		Specify Yes or No-	USA 14. B	ace - Americ	an Indian.
336	72 hours after death with the Maryland natural", or items 23a or 28a-f show deal Evaniner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 第 Divorced	Armed Forces? 1		fYes, specify Cub I □Yes 2 🙀No	dispanic Origin? (S an, Mexican, Puer Specify:	o Rican, etc.)	Spec	lack, White,	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Evantime must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	College (1-4or 5+)	16a. Deced (Give life, I	dent's Usual Occup kind of work done OO NOT use retire	oation during most of wo d)	rking	16b. Kind of		-
121	filed wi Hygier Sther th		12 17. Father's Name (First, Middle, Last)	3	nur	se	18. Mother's Na	me (First, Middle,		lth ca	re
anc	ould be filed Mental Hygi arked other atic event, I	To Be	James Thomas Bri	tt				irginia 1		,	
Maryland	and 2 should be filed eaith and Mental Hygi n 27 is marked other her traumatic event, II	F	19a. Informant's Name/Relationship (7)// Virginia Wiggins/				and Number or R				
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If Item 27 i any injury or other tra once.		20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		sition (Name of natory or other pla	i	Date /OO	20c. Location	·	
Baltir	permit. Page Department of Important: If any injury or once.		21 Signature of Funeral Service License		22	HOTI and Add	ory : 3/7, Füfferal Hill Rd.	Home Pro	<u>Salisk</u> ofessio oury, M	nal As	ssociation
	Physician		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	cations hat caused the e cause in each line.	death. Do not ent		ng, such as cardia		D .	150	Approximate Interval Between Onset and Death
	The law requires that the death certificate be executed with the law required by the attending physician and use as the burial-transit as 2 should be detached for use as the burial-transit	edical Examiner	resulting in death) Social land liter on ditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):						
O. Box 6	that the death certificated by the attending produced for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnan ☐ Other (specify) _	су			Date of delive Month	ery Day Year
rds, P.	w requires that s been signed b should be deta	by	Part II. Other significant conditions con	_	t resulting in the u	nderlying cause gi	ven in Part I.		obacco use co Yes 2 □ No		he cause of death? pably 4 Onknown
of Vital Records,	sician: The law red certificate has bee irector, page 2 shor	Completed						24a. Was autop perfo 1 □Yes		b. Were auto prior to co death? 1 □ Yes	opsy findings available impletion of cause of
Vita	ician: Sertific ector,	Be (25. Was case referred to medical examiner?	lospital:		I Ot	hor:	ath (Check onl			
of	ding Physician: The In. After this certificate he funeral director, page	۲ <u>.</u>	1 Yes 2 No Canal Yes	28a. Date of Injury	2 ER/Outpatie	III 3 LI DOA	4 🗆 Nursing	Home 5 Resident			fy)
Division	or Attenater deatl	Certification: To	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day, Ye 28e. Place of Injury - building, etc. (S		M 1]Yes 2□No	28f. Location (: City or Tox	Street and Nui wn, State)	mber or Run	al Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	Medical C	29a. Certifier (Check only one)	sician: To the best of m ner: On the basis of exa and manner stated.	y knowledge, dea amination and/or in	th occurred at the three	time, date and place opinion, death occ	ce, and due to the curred at the time,	cause(s) and date and plac	manner as se, and due t	stated. o the cause(s)
	To the comp	Me	29b. Signature and title of certifier	w	MD	29c. Licen	se number		29d. Date sig	ned (Month,	Day, Year)
	Ugu		30. Name and address of person who co	MAPPA 61	14 B En		SHIKE	My S	Alishu	MY K	40 21804
	St	ate	31. Date filed (Month, Day, Year)	32 Registrar's	Signatur	aker					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 24, 2009 **Physician** February BARBARA FILNER 1:10 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery 7008 Richard Drive 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Nov • 15,1941 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2√□ F 113-32-2509 67 Pennsylvania Yrs. **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I've Mcdical Evaluate in the netitied at any Injury or other traumatic event, I've Mcdical Evaluate in the netitied at any ones. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Bethesda 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7008 Richard Drive 20817 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No White Specify. ģ 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry
Howard Hughes Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Foundation Grants Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Filner Lily Cohen ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7008 Richard Drive Bethesda, Maryland 20817 Harry Rosenberg -husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State King David Memorial Gardens 2/27/2009 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 18 MONTOS Immediate Cause (Final disease or condition resulting in death) Lung Cancer **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): a Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
24 hours after death.
Puneral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit letely filled in by the funeral director, page 2 should be detached for use as the burial-transit attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 12 No 2 XNo 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 X Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖒 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D017211 February 24, 2009 eu (se

12

State Registrar 31. Date filed (Month, Day, Year) 92. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Kenneth Goldstein, M.D. 5530 Wisconsin Ave., #1125 Chevy Chase, Md. 20815

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 27, 2009 **Physician** February 3:21 A M Fantle Geraldine /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery 5610 Wisconsin Ave. #607 Chevy Chase If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 1 F 02/16/1924 Ohio 279-26-6092 85 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinal must be notified at 1 ☐ Yes 2 ♣ No MD Chevy Chase Montgomery Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 20815 United States 5610 Wisconsin Avenue #607 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 1 ☐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ∐Yes 2 ∐XNo Specify: <u>\$</u> 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mayme Schuman Arthur Gottlieb 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 is other tra Jeffrey Fantle / Son 118 Ridgepoint Place Gaithersburg, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If iter
any injury or ott 1 → Burial 2 □ Cremation 3 □ Removal from State King David Cemetery 03/01/2009 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licenspe 5130 Wisconsin Ave. NW Washington, DC 20016 Willia 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiorespiratory Arrest Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dementia (End Stage) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ner Due to (or as a nonsequence of): The law requires that the death certificate be executed Exami Lymphoma and -trar resulting in death) Last Due to (or as a consequence of): burialphysician s the buria Box 68760 Physician/Medical attending for use as 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) signed by the a d be detached f P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ∐Yes 2 DXNo 1 ☐ Yes 2 ☐ No Division of Vital Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 TResidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred tal or Attending Pres after death.
al Director: After ed in by the funer 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C completely filled Hospital 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD037675 02/28/2009 completed cause of death (Item 23a) (Type, Print) Namirah Jamshed MD 5104 Westpath Ct. Bethesda, MD 20816 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 03 Registrar

DHMH 17 Rev 1/2001

Funeral Director Baltimore, Maryland 21215-0036

Examiner P.O. Box 68760, Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deat 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 2009 March Roy Leon FUNKHOUSER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Williamsport
If Under 1 Year | If Under 24 Hrs. 10824 Archer Lane Washington Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1**∑** M 2□ F Yrs. 1933 Maryland Sept. 220-30-9340 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2√ No Director Washington Williamsport Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number by Funeral 10824 Archer Lane 21795 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 21 Married 1 ☐ Yes 2 😿 No Specify: Specify. 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Insurance agent Insurance company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary C. Brown 2 John C. Mullin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gloria Funkhouser - Wife 10824 Archer Lane Williamsport, Maryland 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State Paul's Cemetery 3/6/09 4 Donation 5 Other (Specify) Clear Spring, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 415 E. Wilson Blvd. Hagerstown, Maryland 21740 Immediate Cause (Final **Physician** -U15 Canc disease or condition resulting in death) /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Be Completed by Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funneral director, page 2 should be detached for use as the burial-transit completely filled in by the funneral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Mr chas 41667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mesenhun Comos SH TH mack 11110 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Gruber February 26, 2009 1:50 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Potomac Valley Nursing Home Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 5. Social Securify Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2**K** F Yrs. 3, 1925 Pennsylvania Jan. **Director** 578-60-7207 Usual Residence of Decedent D the Maryland 10d. Inside City Limits 10c. City, Town or Location ural", or items 23a or 28a-f sho Examinar must be notified at 1∭XYes 2 ☐ No Rockville Montgomery Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20850 U. S. A. 1235 Potomac Valley Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after al Hygiene. other than "natural", or ite 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No Specify: ð 3 XVidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 10th Grade permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if Item 27 Is marked othe any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Goldie Petchen Sidney Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20850 23 Marwood Court, Rockville, Maryland Ruth F. Herson - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 3/2/2009 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mount Lebanon 22 Name and Address of Facility Edward Sagel Funeral Direction, Inc. 21. Signature of Funeral Service License Donald tottlem 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardiac Arrythmies Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as e consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Year Month Day 5 ☐ Other (specify) 9 Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Stroke Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate ! 1 □ Yes 1 ☐ Yes X☐ No 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No After this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 Homicide

Division of Vital Records, P.O. Box 68760 Hospital within 24 hours a To the

> State Registrar

cal

Dr. Sayed ElSayyad 31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier

(Check only one)

29b. Signature and title of certifier

10110 Molecular Dr. Suite 206, Rockville, Maryland 20850 Registrar's Signature

1 ី CertifyIng Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0062435

29d. Date signed (Month, Day, Year)

February 26, 2009

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 26, **Physician** 2009 February 7:15 PM Mary Louisa Green /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Wilson Health Care Center Gaithersburg 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🛱 F 215-30-5014 Director 94 July 31,1914 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d, Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any Injury or other traumatic event, the Medical Examinat must be notified at Director MD Montgomery Gaithersburg 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 Russell Avenue 20877 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify White ò 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Towing Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wellington Waddell Smith Mary Jane Pearce ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane G. Mangels /Daughter 12 High Sheriff Trail, Ocean Pines, MD 21811 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lorraine Park
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State March 2009 4 Donation 5 Other (Specify) Baltimore, MD 21. Signature of Funeral Service License DeVol Funeral Home, Gaithersburg, MD 10 East Deer Park Drive, 20877 eutis 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Uremia Months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 1 ☐ Yes 2 X No 5 Other (specify) P.O. the 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 ☐ Yes 2 XNo 1 ☐ Yes 2 ☐ No Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 X Natural 5 Pending investigation Injury To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Kcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 🖂 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D19294 February 27, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Melnick M.D., 911 Russell Avenue, Gaithersburg , MD 20879 John R. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State parked Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1- State Amended item #5, WCHD, SLU, 03.04. Certificate of Death Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 2009 Deinie February 25 5:08 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Nursing Home Salisbury Wicomico 8. Date of Birth (Month/Day, Year) 5. Social Security Number 252-36-4904 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) 1 ☐ M 2 🗙 F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No MO Director Wicomic alisbur 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? (15. A 2180 405 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 9 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tautro 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Pages 1 and 2 should be mmic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) V) as 615 Hammond MD 21804 vonne daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 31 Hemorial 2009 Hebron MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 917 W. Isabella Street Bennie Smith MD 21501 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIOVASOUL MHEROSCIEKATIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for 1 in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 Tes 2 No 3 Probably 4 Dunknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has autopsy death? 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1☐ Yes Division or Vital 2 2 No Be 25. Was case referred to medical examiner? 26. Place o Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 🗌 Inpatient 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 614 Eastern Shore Drive, Salisbury, MD 21804 Maesha Thimmarayappa, MD 31. Date filed (Month, Day, Year egistrar's Signature State 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08375 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year John Μ. Gavigan 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death REGIONAL MEDICAL TENINSULA SALISBUM HIOSMICO If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1**⊠** M 2□ F Months Days Hours Min. 073-52-0495 45 09/28/1963 New York Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Maryland Wicomico Hebron 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7606 Pondview Drive 21830 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 Mano If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: white 3 Widowed 4 Divorced Specify: 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) musician music 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harold Gavigan Beatrice Unger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Gavigan/brother 26420 Quantico Creek Rd., Hebron, MD 21830 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Ki Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 2/28/09 Salisbury, MD 21. Signature/of Juneral Service Licer 22 Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as pardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) to (or as a consequence of): to (or as a consequence of): ce of):

Physician /Medical **Examiner**

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attending physician for use as the burial

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After this certificate

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To the Hospital Vithin 24 hours a To the Funeral C the Hospital

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Department of Health Important: If item 27 any Injury or other trootice.

Pages 1

or Attending Physician: The law requires that the death certificate be executed

Box 68760,

P.O.

of Vital Records,

Division

Physician

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10a. State

Funeral

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28a-f show

Director

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7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be retified at

72 hours after

ill Hygiene.

Health and Mental Hyginem 27 is marked other

Baltimore, Maryland 21215-0036

Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last

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1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 3 Ectopic pregnancy 5 ☐ Other (specify) 9 Unknown

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No

9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Z Unknown 24a. Was an autopsy performed? Yes 2 2 No 1 □ Yes

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

Year

25. Was case referred to medical examiner? 1□Yes 2☑No 27. Manner of Death

5 Pending investigation 6 ☐ Could not be

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 ER/Outpatient 3 DOA Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5 ☐ Residence 6 ☐ Other (Specify)

29a, Certifier (Check only one)

1 Natural

2 Accident 3 Suicide

4 Homicide

Lecritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of tiji)£ 29c. License number

29d. Date signed (Month, Day, Year)

State

MEHTA MI riyush 31. Date filed (Month, Day,

100 E. CARROLL 32. Registrar's Signature

26. Place of Death (Check only one)

Other: 4 Nursing Home

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene > 1 For State RegistrarAMEND#7,8perINF,3/10/09,BMW,McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 0815 26 2009 February Francis Leon /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring Montgomery 1412 Stateside Drive If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year)1935 Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 ☐ F April 08, 1934 Tennessee Director 409-58-9432 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20903 U.S.A. 1412 Stateside Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Ite 1 XX Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Itimore, Maryland 21215-0036 1 ☐ Yes 2 X No Army Specify. Completed by 3 Widowed 4 Divorced White Koreá 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Journalist Self Employed 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Lee Haney 2 Francis Leon Howell, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1412 Stateside Drive, Silver Spring, Maryland 20903 Barbara Howell - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If It any Injury or conce. 1 ☐ Burial 2 【■ Cremation 3 ☐ Removal from State Fort Lincoln Crematory 03/04/2009 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licens Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Q Hear disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-trans 10000 Due to (or as a consequence of): dical

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

ysician/ine	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	al death 3 Ectopic pr			23d. Date of delivery Month Day Year
ed by Pri	Part II. Other significant conditions of	contributing to death but not res	ulting in the underlying o	ause given in Part I.		o use contribute to the cause of death?
ompier					24a. Was an autopsy performed?	
e	25. Was case referred to medical			26. Place of Dea	ath (Check only one)	
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ation:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred
verillic.	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, street, factor	y, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
glical		nysician: To the best of my kno miner: On the basis of examina and manner stated.				(s) and manner as stated. and place, and due to the cause(s)
Me	29h. Signature and title of certifier	7	29	c. License number	29d. [Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

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moom 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. 2009 Physician Daniel James Harrigan Jr. February 28, 4:45 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner
 Renaissance Cardens Riderwood Village

 ocial Security Number
 6. Sex

 7. Age (In yrs. last birthday)
 Prince George's Spring ar If Under 24 Hrs. Silver S 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 x M 2 □ F Yrs. Director 93 157-10-1644 Oct 21, 1915 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exoration count be notified at Director 1 ☐ Yes 2 ▼ No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3128 Gracefield Road, Funeral #101 20904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 1942– Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 T Married 1 ☐ Yes 2 TvNo Specify \$ Specify. 3 Widowed 4 Divorced 1942-46 White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Project Manager Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel James Harrigan, Sr ည Harriett Joachim 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau once. 3128 Gracefield Road, #101 S Helen B. Harrigan / Wife Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 03/03/2009 Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cerebrovascular Accident days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last years Examine Due to (or as a consequence of). attending physician and for use as the burial-transi Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 🗆 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 1 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide

law requires that the death certificate be executed P.O. Box 68760 Records. Division of Vital

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Pages 1

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ficate has been si ; page 2 should b certificate Hospital or Attending Physician: director this funeral After t death. 24 hours after death Funeral Director: filled in by the npletely the To the within 7

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Medical

State Registrar

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) D24035 March 2, 2009

31. Date filed (Month, Day, Year)

Eugenio Machado, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



3110 Gracefield Road, Silver Spring, MD 20904

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2009 7:50 a^M 26, Nancy Clarkson February Irey /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner** Montgomery 2712 Plyers Mill Road Silver Spring If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July 100 th 102% 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** ^{Ye}1'948 1 □ M **%**√√ F 60 235-76-9736 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10h. County 10a. State 28a-f show ns 23a or 28a-f sho 1 ☐ Yes 2 No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20902 USA 2712 Plyers Mill Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 White 1 ☐Yes 2 🔀 No Specify. Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Financial Management Accountant of the state of th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Walter C. Clarkson Virginia Mary Clarkson ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau 2712 Plyers Mill Road, Silver Spring, MD 20902 John Phillip Irey/Husband Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Feb. 26, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd., W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 days Sepsis /Medical Due to (or as a consequence of): Examiner Multiple Sclerosis years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical nding p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 3 Ectopic pregnancy Day 5 Other (specify) ned by the a detached f P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à sign be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown as been si Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page perform death? 2 **X** No 2 □No 1 ☐ Yes 1 ☐ Yes of Vital 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27, Manner of Death 28d. Describe how injury occurred Division Hospital or Attending 1 🖺 Natural 5 Pending 1 ☐ Yes 2 🗆 No investigation death. 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide after To the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D60325 February 26, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Rebecca M. Gross, MD 10400 Connecticut Avenue, #606, Kensington, MD 20895 31. Date filed (Month, Day, Year) Registrar's Signature MAR 03 Registra

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Physician / Medical Examinor Physic	/lan	uld be Menta rked ric ev		Wasil Parafin					Anna To	mbakiev	vicz		
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Physician Medical Examiner Part	Balt	permit. Departi Importi any inji		21. Signature of Funeral Service	R. Bug	912	22	2. Name and Addre	ess of Facility ${ m Jos}$	-			
The property of the part of				23a. Part 1. Enter the disease, of shock, or heart failure. Lis	or complications that ca	used the death	n. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory	arrest,		Interval Between
Due to (or as a consequence of): Due to (or as a consequence of):				disease or condition	_a. Arter:	ioscler	otic C	ardiovas	cular Dis	ease			
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Styling Styl	B	ecuter and -transi	cami	Cause (Disease or injury that initiated events resulting in death) Last	C								
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The state of the	_				a								
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State Part		ss that gned t	y P		-		-			23e. Did	tobacco	use contribute to	the cause of death?
State Part	ord	een si	ted	Hypertension,	Coronary A	rtery D	isease	e, Dement	<u> 1a</u>	1 🗆	Yes 2	2 [*] No 3 □ Pr	obably 4 Unknown
Signature and address of person who completed cause of death (Item 23a) (Type, Print) Shyamsundar Rajan MD 9801 Georgia Ave. #117 Silver Spring, MD 20902 State 25. Place of Death (Check only one) Assisted 26. Place of Death (Check only one) Assisted 26. Place of Death (Check only one) Assisted 26. Place of Death (Check only one) Assisted 27. Manner of Death 1	l Rec	The la	omple							auto	opsy formed?	prior to death?	completion of cause of
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Shyamsundar Rajan MD 9801 Georgia Ave. #117 Silver Spring, MD 20902 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		To the within	Ň	29b. Signafure and trile of certifie	amsin	dar	V						
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		10							lver Spr	ing, MD	209	002	
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09-01982 Eric Jones

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ric Jones		Sta 1- For State	ate of Maryla	and / Depa		Health ar			ne		200	19	0838
Physic		Registrar. 1. Decedent's Name (First, Middle	e,Last)						e of Death	No.	.:	3. Time	e of Death
ledical Exam		Eric Christo	pher Jo	nes				Mor Mar	ch 9, 20	09	Year	144	10 hrs
		4a. Facility Name (if not institution		ımber)	4	b. City, Town, o	r Location of	Death			inty of Deat Arunde		
		Anne Arundel Medical 5. Social Security Number	6. Sex	7. Age (In yrs. I	last hirthday\	Annapolis If Under 1 Year	ar If Under:	24Hrs 18 D	ate of Birth		YYYY 9. B		(State or
Funeral Director						Months Day		Min.		,	Fore	ian	
	re in 1844	578-02-3347 Usual Residence of Decedent	1 X M 2 F	47	Yrs.			8/	/27/1	1961		ountry)	MD
amy.	1,74,94	10a. State 10b. County		10c. City	, Town or Location	on				- ,	,.	10d. Ir	side City Limits
*	ž	MD Pr. (George's	3		Forest	ville	9				1 X	Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number		· · · ·		10f. Zip Code			10g	. Citizen o	of What Co	untry?	
th the Maryland 23a or 28a-f sho notified at once.		1404 Woodlar	k Drive				747			U	SA		
th witi ems 2 t be n	Funeral	11. Marital Status 1 X Never Married 2 Ma		cedent Ever in U orces?	l.S. 13. Was	Decedent of Hes, specify Cuba	ispanic Origin ın, Mexican, F	n? (Specify Y Puerto Rican,	es or No- etc.)		Race - Ame White, etc.	rican Ind	an, Black,
er dea , or it			1 Yes	2 X No	1	Yes 2 X N	o specific			Spe	cifu: TaT	hite	
72 hours after death with the Maryland n"maturial", or items 23a or 28a-f sho ral Examiner must be notified at once	d by	15. Decedent's Education (Spec	or Dates:		16a. Decedent	's Usual Occupa	ation (Give kir		ne .		of Business		
72 hou 11 "nai	Completed	Elementary/Secondary (0-12)		1-4 or 5+)	during mo	st of working life	e. DO NOT us	se retired)	-	7.7			
5-0036 fled within 72 Hygiene. I other than "the Medical	ldm	10		V	Equip:	ment O	perat	or		Cons	struc	ctio	n
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle,	,		•			Name (First,			name)		
21215 21215 ould be fill Mental H marked c event, t	To Be	Byron L. Jo 19a. Informant's Name/Relations			19h Mailing	Address (Stre		ilde			Town Stat	te Zin Co	nde)
MD 2 d 2 shou fith and N n 27 is n	4 1	Mathilde Jone		r		Woodla							· ·
tra lea		20a. Method of Disposition		20b.	Place of Disposi	tion (Name of co		Date	1	20c. Loca	tion - City o	or Town, S	State
Baltimore, permit. Pages 1 ar Department of Hee Impordant: If ite		1 Burial 2 X Cremation		TOTT State	crematory or oth		am 3	3/16/0	9 1	3e1t	svi1	10.	MD
Baltin permit. P Departine Importar		4 Donation 5 Other Sp 21. Signature of Funeral Savice		101	22. N	ame and Addres	s of Facility	Paymo	ond - I	book	F H	- · ·	7
		C. Wor	1		10	Box 43	30, Di	ınkirl	c, MI	20	754	• , [• A •
Physician		23a. Part I. Enter the disease, or failure. List only one cause	complications that on each line. At	aused the death	Do not enter the	e mode of dying	such as car	rdiac or respir	atory arres	t, shock,	or heart		oximate Interval ween Onset and
/Medical xaminer		Immediate Cause (Final disease	a									1	Death
		or condition resulting in death)	Due to (or as a	a consequence o	of):								
	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of	of):							1	-
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated	C. Due to (or as	a consequence (nf).							-	
uted id ansit	Ä	events resulting in death) Last	d.	a consequence (51).								
be executed ician and irial - transit	dical	XUNPENDED	AMENDED	23a,27	, per M	E g889	3/18/0	9 TT					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death to the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the finneral director, page 2 should be detached for use as the built.	Med	IF FEMALE:		outcome of preg	gnancy					23d. Da	ate of delive	ry	
68 certifi nding se as t	jan/	23b. Was decedent pregnant in the past 12 months?	LIVE	birth nant at time of d		a. death	Ectopic	pregnancy		Mor	nth	Day	Year
Box 68760 e death certificate be the attending physi ed for use as the bu	Physician/Me	1 Yes 2 No 9 Uni	known g Unkn		eath 5 Oth	ner (Specify)							
that the ned by the detached	0-	Part II. Other significant condit	ions contributing t	to death but not	resulting in the u	nderlying cause	given in Part	t I. 2	3e. Did tob	acco use	contribute t	o the cau	se of death?
ires that the signed by	d by							_	1 Yes	2 No	3 ✔ Pr	obably 4	4 Unknown
ords v requ s been should	Completed							2	4a. Was ar autops				ndings available ion of cause of
Cecc The lay ate ha	l ii							1	✓ perform ✓ Yes 2		death?		2 N o
Division of Vital Records, P.C real or Attending Physician: The law requires that is after death al Director: After this certificate has been signed eld in by the funeral director, page 2 should be determed in each in by the funeral director.	Be C	25. Was case referred to medica				26.Plac	ce of Death (0	Check only or	ne)				
n of Vital I ling Physician: After this certifi funeral director,	To E	examiner? 1 ✓ Yes 2 No	Hospital: 1		ER/Outpatient			Nursing Hom		Residence	L	er:	
n of ling P After funera	l ::	27. Manner of Death 1 X Natural 5 Pend		e of Injury h, Day,Year)	28b. Time of Ir		iury at Work?		Describe ho	ow injury a	ccurred		
Sior Attend death death sector:	catio	o I circ	stigation				Yes 2				t t	North David	As Niverbay City
Division pital or Attent ours after death leral Director: filled in by the	Certification:	deter	d not be 28e. Place (Specify)		nome, farm, stree	t, factory, office	building, etc.		r Town, St		number or F	Kurai Rou	te Number, City
Division Hospital or Attent 24 hours after death Funeral Director: stely filled in by the		29a. Certifier	hysician: To the be		dae death easur	rad at the time	date and plac	se and due to	the cause	(e) and m	anner ac et	atad	
Division To the Hospital or Attention within 24 hours after deart To the Funeral Director: completely filled in by the	Medical		miner:On the basis	of examination									e(s)
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Me	29b. Signature and title of certifie	and manner:	stated.		29c. Licer	nse number			29d. Date	signed (M	lonth, Da	y, Year)
		1 Laula	lo 1111			0.0	.M.E.		-	March	10, 2009)	
		30. Name and address of person	who completed cau	use of death (Iter	n 23a)								-
		Laron Locke MD. A	ssistant Medica	al Examiner	111 Penn	Street, Balt	imore, MD	21201					
	tate	31. Date filed (Month, Day, Year)	2 2009 32.R	egistrar's Signat	ture /	* *P 6							
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Amend #1,perPHYS,

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Department of Health and M Certificate of Death	Reg. No.	08382
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			State Amend Registrar		aryland / Depa Ce	rtificate of	Death	R	eg. No.		
	Physici	an	1. Decedent's Name (First, Middle, L	morgan	"aka Marvi		er Jones	2. Date of Deat Month	th Day	Year	3. Time of Death
97-	/Medi			Mergan Le	ster Jones	,aka " M	arvin"	February		2009	12:16 P M
	Examir	er	4a. Facility Name (If not institution, g	ive street and number)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	r Location of Death		4c. Cour	nty of Death	
. 40-	<u> </u>		Calvert Memorial Hosp			Prince Fred			Calver		
	Funeral		Social Security Number 6.	Sex 7. Ag 1 ☑ M 2 ☐ F	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	Date of Birth (Month, Day)	Year)	9. Birth Cou	place (State or Foreign ntry)
	Director		214-58-0969 Usual Residence of Decedent		58 118.			October 1	7, 1950	Mary	land
	and		10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits
	Mary f sho	0	MD Calvert		Prince Frede	rick					1 ☐ Yes 2 🎇 No
	the 28a	Director	10e. Street and Number		7	10f. Zip Code		1	0g. Citizen o	of What Cou	ntry?
	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at		1271 Carls Count				20070		USA		,
	ms 2	Funeral	1371 Sark Court 11. Marital Status	12. Was Decedent	Ever in U.S. 13.		20678 fispanic Origin? (Spec an, Mexican, Puerto F			lace - Ameri	can Indian,
(0	or ite		1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ∑Yes 2 ☐ I If Yes, Give	No			lican, etc.)	В	lack, White,	etc.
03	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Spe		ack
21215-0036	72 ho natur lical	Completed	15. Decedent's i	Education	16a. Dece	dent's Usual Occup	oation during most of workin	σ.	16b. Kind of		
21	within 7 iene. than "i	ag.	Elementary/Secondary (0-12)	College (1-4or 5	life.	DO NOT use retire	d)	9			
7	filed wi Hygien other th	ပ္ပ	12		Labo	rer			Co	nstructio	on
Maryland		Be	17. Father's Name (First, Middle, Las	st)			18. Mother's Name	(First, Middle, I	Maiden Surn	ame)	
yla	2 should be and Mental Is marked aumatic ev	은		al Jones					dred Gro		
lar	2 sh and Is m		19a. Informant's Name/Relationship	(Type. Print)	19b. Mailii	ng Address (Street	and Number or Fural	Route Number	, City or Tou	vn, State, Zij	o Code)
	and lealth m 27		Dorene Jones - Wife				Prince Frederic				
Baltimore,	ges 1 If ite or otl		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3	☐Removal from State	20b. Place of Dispo cemetery, cre-	osition (Name of matory or other pla	ce) 3/13		20c. Locatio	n - City or T	own, State
Ë	men tant:		4 ☐ Donation 5 ☐ Other (Spec	rify)		n Veterans C	em. 3/10/20	· 1	Cheltenh	nam. Mi)
3aii	permit. Pages 'Department of H Important: If ite any Injury or of		21. Signature of Funeral Service Lic		, 2	2. Name and Addre	ss of Facility			,	
	0 0 7 € 0		Heolips Q.	-						ince Fred	erick, MD 20678
4:			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused y one cause on each li	I the death. Do not en ne.	ter the mode of dyi	ng, such as cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	_ HEPAT	URENAL	SYNDRO	M E				Low clays
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9	ath certific ttending p or use as	lan/Medic	23b. Was decedent pregnant	d23c. If yes, outcome	pf pregnancy 2 □ Fetal death 3 □	⊒Ectopic pregnanc	y		1	Date of deliv	•
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s, P.O. Box 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Completed by Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions 1 □ T N E T O ► 1 A 25. Was case referred to medical examiner? 1 □ Yes 2 □ No	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown contributing to death b	pf pregnancy 2 Fetal death 35 time of death 55 ut not resulting in the u	Other (specify)	en in Part I. 26. Place of Death er: 4 \(\text{Nursing Hom} \)	1 Ye 24a. Was al autops perforr 1 Yes 2 (Check only onle 5 Reside	pacco use consect of the pack	ontribute to t 3 Prol b. Were autor prior to co death? 1 Yes	Day Year he cause of death? bably 4 □Unknown posy findings available impletion of cause of 2 □Vo
or Vital Records, P.O. Box 6	Physician: The law requires that the death certificate has been signed by the attending rail director, page 2 should be detached for use as	To Be Completed by Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions TN ETOH A 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending	d. 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown contributing to death b BUSE □ □ i Hospital: 1 □ Inpatie 28a. Date of Inju (Month, Da	pf pregnancy 2 Fetal death 3 time of death 5 time of death 6 t	Other (specify) nderlying cause given at 3 DOA Other 28c. Injur Wor	26. Place of Death ver: 4 \square Nursing Hom vk?	1 Ye 24a. Was al autops perform 1 Yes (Check only on	pacco use consect of the pack	ontribute to t 3 Prol b. Were autor prior to co death? 1 Yes	Day Year he cause of death? bably 4 □Unknown posy findings available impletion of cause of 2 □Vo
or Vital Records, P.O. Box 6	ung Physician: The law requires that the death certifin. After this certificate has been signed by the attending I funeral director, page 2 should be detached for use as	To Be Completed by Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions T N E T O H	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown contributing to death b BUSE DI	pf pregnancy 2 Fetal death 3E time of death 5E ut not resulting in the u C ent 2 EF/Outpatier ry y Year) 28b. Time o	Other (specify) Inderlying cause give Int 3 DOA Other 28c. linjun Wor 1 1 1 1 1 1 1 1 1	26. Place of Death er: 4 □ Nursing Hom y at k? Yes 2 □ No	24a. Was at autops perform 1 Yes (Check only on e 5 Reside	pacco use consess 2 No	ontribute to to a 3 Frol b. Were autoprior to co death? 1 Yes Other (Special curred)	Day Year the cause of death? bably 4 □Unknown posy findings available impletion of cause of 2 □ √o
or Vital Records, P.O. Box 6	or Attending Physician: The law requires that the death certifiter death. Nirector: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as	To Be Completed by Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions TN ET N 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending	23c. If yes, outcome 1	pf pregnancy 2 Fetal death 3E time of death 5E ut not resulting in the u	Other (specify) Inderlying cause give Int 3 DOA Other 28c. linjun Wor 1 1 1 1 1 1 1 1 1	26. Place of Death er: 4 □ Nursing Hom y at k? Yes 2 □ No	24a. Was at autops perform 1 Yes (Check only on e 5 Reside	pacco use co	ontribute to to a 3 Frol b. Were autoprior to co death? 1 Yes Other (Special curred)	Day Year he cause of death? bably 4 □Unknown posy findings available impletion of cause of 2 □Vo
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29b. Signature and title of certifier

29c. License number

D36969

LUSBY

MD 2065>

29d. Date signed (Month, Day, Year) 2/27/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATHEW MD POBOX 1789

31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

		,	1 - For State of State of Registrar	Maryland		rtment of F		Mental Hyg	iene _{eg. No.} 2009	08383	
F		-4	Decedent's Name (First, Middle, Last)					2. Date of Dear	th	3. Time of Death	
	Physici /Medic		Dorothy Louise		ollif			March	2 ^{Day} 2009	9:05 AM	
¢.	Examin	er	4a. Facility Name (If not institution, give street and numb			•	r Location of Deat		4c. County of Dea		
-	Funeral	J.	Williamsport Nursing 5. Social Security Number 6. Sex 7.	Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth	Washin	thplace (State or Foreign	
	Director		217-28-5933 1 ¹ M 2X F	75	Yrs.	Months Days	Hours Min.	Decembe	year) 9. Bir er 26, 1933	B Maryland	
	pug "	ja II	Usual Residence of Decedent 10a, State 10b, County	10c. City.	Town or Lo	cation	_			10d. Inside City Limits	
	Maryla f sho	ror	Maryland Washington		agers					1 □Yes 2 □ No	
	r 28a	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	ountry?	
	th with	al D	335 Valley Road			217	40		U.S.A.		
920	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decede Armed Force 1 Section 1 Tyes, Give Year or Date	'	Vas Decedent of H f Yes, specify Cub I □ Yes 2□X\lo		Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whi Specify: W	te, etc.		
2 O	72 ho 'natur dical J	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occup	ation during most of wo	rking I	16b. Kind of Business	/Industry		
2	vithin "ne.	Completed	Elementary/Secondary (0-12) College (1-4	or 5+)		kind of work done OO NOT use retire Memaker	d)	9	Own Ho	m o	
0 0	filed with Hygiene ther thai	ပ္ပိ	17. Father's Name (First, Middle, Last)		1101	II C III G K C I	18. Mother's Nar	me (First, Middle, I			
Baltimore, Maryland 21215-0036	should be I and Mental s marked o' umatic eve	To Be	Lawrence William	Bart	con	:	Hazel	Mari	e Hawb	aker	
lary	es 1 and 2 of Health a f Item 27 Is r other tra		19a. Informant's Name/Relationship (Type. Print)						; City or Town, State,		
≥ ഹ്			Edward L. Jolliffe Sor			Kemps M	ill Road		nsport, Md		
פֿר			1 X Burial 2 ☐ Cremation 3 ☐ Removal from Sta	cei	metery, cren	natory or other pla Memoria			20c. Location - City or lagerstown		
Ħ	permit. Pag Department Important: I any injury o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	φοααι						-	
ñ	Dep Imp any		I B. hoel brodg		40	East An	tietam S	treet, Ha	al Home, In ngerstown,	Md. 21740	
			23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	sed the death.	Do not ente	er the mode of dyi	ng, such as cardia	c or respiratory arre	est,	Approximate Interval Between Onset and Death	
	hysician /Medical	ģ.	Immediate Cause (Final disease or condition resulting in death) a. Lung Cancer with metastaces. Due to (or as a consequence of):								
plant of	Examiner										
١,		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
	scuted nd transit	Examiner	Cause (Disease or Injury that Initiated events resulting in death) Last								
8760,	cate be executed ohysician and the burial-transit	EX	Due to (or	as a conseque	ence of):						
687	ficate physi s the b	edical	d								
Box	leath certific attending p	In/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birt		23d. Date of de	livery					
0.8	The law requires that the death certificate be executed to has been signed by the attending physician and lage 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months? 1 ☐ Yes 2 No 4 ☐ Pregnar 9 ☐ Unknown 9 ☐ Unknow	<i>y</i>		Month	Day Year				
٦.	ires that the de signed by the a 1 be detached f		Part II. Other significant conditions contributing to deal	23e. Did tob	acco use contribute to	the cause of death?					
Vital Records,	quires n sign	d by						1 (2 KÝ c	es 2□No 3□P	robably 4 □Unknown	
ဂ္ဂ	aw requir s been si 2 should b	Completed						24a. Was a		utopsy findings avail <i>a</i> ble	
Ä		mo						autops perforr	ned? prior to death? 2 ☑ No 1 ☐ Yes	completion of cause of 2 ☐ No	
/ita	sician: Th certificate rector, paç	Be (25. Was case referred to medical examiner?			l au		ath (Check only on	-/-		
	Physi this c	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inp 27. Manner of Death 28a. Date of		R/Outpatien 28b. Time of		4 LOUVUISING F		ence 6 Other (Spe	cify)	
Division or	or Attending Physician: ifter death. Director: After this certifica in by the funeral director, p	Certification:		Day Year)	Injury	Wor	yai k? Yes 2∐No	280. Describe no	w injury occurred		
N S	I or Attence after death Director:	tifica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of	l f injury - At hom j, etc. <i>(Sp</i> ec <i>ify)</i>		eet, factory, office		28f. Location (St. City or Town	reet and Number or R	ural Route Number,	
5	ital or irs afte rai Di	Cert									
	Hosp 24 hou Fune etely fi	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the bear and manner.	is of examination	rledge, death on <i>a</i> nd/or in	occurred at the ti	me, date and place opinion, death occ	e, and due to the caurred at the time, d	ause(s) and manner as ate and place, and du	s stated. e to th <i>e</i> cause(s)	
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Me	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date signed (Moni	h, Day, Year)	
			on suchat			D3	3700	0	March 3,	2009	
	611 -		30. Name and address of person who completed cause			Print)					
0	5H-3	to	IED E. HOUE 15 31. Date filed (Month, Day, Year) 32. Reg	gistrar's Signatu	, AZ	MASIT	ST, U	ILLIAMO	PORT, M	D 21795	
	Sta Registr		MAR 0 4 2009	44944	1. 1	3 Kerl					

DHMH 17 Rev 1/2001

Dorothy Jolliffe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend#13 WCHD 3/209 ead Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2009 **Physician** ones February 015 21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico burg Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Date of Birthy (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex Funeral Days 1 □ M 2 🗂 F Months Hours -40-9852 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County show and 2 should be filed within 72 hours after death with the Maryla feath and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f show her traumatic event, the Medical Examinar must be refilled at 1 ☐ Yes 2 No MD Director omerset trincess 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with I Hygiene. 28 12457 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Racher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health item 27 2/853 olano Anne 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 20a. Method of Disposition Department of Important: If it any Injury or o once. Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Smith Funera schisbury ND 2180 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or rijury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical F FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed? Yes 2 this certificate 1 □ Yes 1 Tyes 2 🗆 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 12 Yes 2 □ No 2X ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient Medical Certification: To nours after death.
neral Director: After this
y filled in by the funeral di 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title

Registrar

DHMH 17 Rev 1/2001

State

100 E.

Carroll St

Salisbury

and address of person who completed cause of death (Item 23a) (Type, Print)

m.D

Snyde

NYIS

31. Date filed (Month, Day, Year)

Y

32. Registrar's Signature

.m.c

State of Maryland / Department of Health and Mental Hygiene ? [] [] 9 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 3:25 aM 2009 Anlin Ku March 01 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Renaissance Gardens - Riderwood Village Silver Spring Prince George's If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)People's Republic of China 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 □ M 2 🖾 F March 01, 1917 Director 466-66-9359 92 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show I and 2 should be filed within 72 hours after death with the Maryla death and Mental Hygiene. Sm 27 is marked other than "natural", or items 23a or 28a-f show the traumatic event, Its Medical Exa, it is a must be notified at 1 ☐ Yes 2X No **Funeral Director** Maryland Prince George's Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 U.S.A. 3148 Gracefield Road, #A410 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗵 No Specify. þ Specify: 3 ₺ Widowed 4 Divorced Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Travel Agent Travel Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ C.F. Chow C.F. Wang 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 1848 Ingleside Terrace, NW, Washington, DC Leighton Ku - Son permit. Pages 1 a
Department of He
Important: If item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 03/06/2009 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1. Enter the disease. Part 1. Enter the disease, shock, or heart failure. List h Immediate Cause (Final disease or condition resulting in death) **Physician** Pulmonary Fibrosis /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) as been signed by the 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Gastrointestinal Bleed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension Atter this certificate has autopsy page 2 No 1 ☐Yes 2 🖾 No 1 ☐ Yes Osteoporosis or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 No Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4₺ Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending ours after death.

leral Director; A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I 29a, Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number ALEXION 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

09-01709	
Jesse Klumn	

esse Klump		State of Maryland / Department of Health a 1-For State Registrar Certificate of Death		giene	. No. 200	10 0838		
Physicia	n/	Decedent's Name (First, Middle,Last)		2. Date of Death Month February 27	Day Year	3. Time of Death 2210 hrs		
Medical Examir		Jesse R. Klump 4a. Facility Name (if not institution, give street and number) 4b. City, Town,	or Location of Death	February 27	7, 2009 4c. County of Death	22101115		
		Penninsula Regional Medical Center Salisbury			Wicomico	6.1		
Funeral Director		213-33-4327 1 X M 2 F 17 Yrs.	ear If Under 24Hrs. ays Hours Min.	8. Date of Birth	(MM/DD/YYYY) 9. Birt Foreig /1991 M	hplace (State or n 紹 文land		
nd show any 10e.	Ĭ	Usual Residence of Decedent 10a. State				10d. Inside City Limits 1 Yes 2 X No		
ith the Maryland 23a or 28a-f show notified at once.	Dir.	10e. Street and Number 2522 Bayview Road 218		100	g. Citizen of What Cour	nat Country?		
r death wi or items	Fune	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 1 Yes 2 X 1	an, Mexican, Puerto F		White, etc.	can Indian, Black,		
urs afte	핡	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occup	pation (Give kind of we		16b. Kind of Business/I	ite ndustry .		
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural".	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) student	ife. DO NOT use retire	ed)	education	1		
		17. Father's Name (First, Middle, Last)	18.Mother's Name		aiden Surname)			
2121 uld be f Mental marked	To Be	Christopher A. Klump 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Str		Lesser ural Route Numb	per, City or Town, State	, Zip Code)		
MD d 2 shortth and n 27 is		Kim Klump/mother 2522 Bayv	iew Rd., G	irdletre	ee, MD 2182			
Baltimore, MD 2121 pemit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is market injury or other traumatic event,		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of crematory or other place) Salisbury Crema	- "	^{Date}	20c. Location - City or Salisbury			
Balt permit. Depart Import injury		21. Signature of Funeral Service Licenses 22. Name and Address Holloway 501 Snow	HILL RO.	Salisb	ourv, MD 21			
Physician /Medical		25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dyir failure. List only one cause on each line.	ng, such as cardiac or	respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death		
`xaminer		Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wound of Head Due to (or as a consequence of):				250.11		
		Sequentially list conditions, b						
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sd sit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
executed ian and al - transit		d. UNPENDED AMENDED						
	ğ	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliver	,		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	sician/I	22h Was decadent progrant in the	3 Ectopic pregnar	ncy		Day Year		
that the d	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	e given in Part I.	23e. Did tob	acco use contribute to	the cause of death?		
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Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should the control of the funeral director, page 2 should the funeral director.	Completed			24a. Was a autops perforr	y prior to oned? death?	topsy findings available completion of cause of		
tal Recision: The certificate	S		ace of Death (Check o	only one)				
n of Vital ding Physician: After this certif	인	1 V Yes 2 No Tospital 1 Inpatient 2 V ER/Outpatient 3 DOA			Residence 6 Other	T:		
Sion of Attending Pl death. ector: After by the funera	Certification:	27. Manner of Death 1 Natural 5 Pending Pending Investigation Accident	Yes 2 V No	Subject shot	self	Doub Number City		
Division of At ours after do neral Direct filled in by	ate) V Drive , Eden, MD	ral Route Number, City						
Division To the Hospital or Attend within 24 hours after death To the Finneral Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.	ion, death occurred at		ind place, and due to th	e cause(s)		
	Σ		ense number C.M.E.		29d. Date signed (Mo March 2, 2009	nth, Day,Year)		
Su		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltin	more, MD 21201					
CA	a.C	31. Date filed (Month, Day, Year) 32. Registrar's Signature						

ORIGINAL

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 **Physician** Gladys M. Lang 9:00a M February 26, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fox Chase Rehabilitation and Nursing Center Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 □ M 2 🛣 F 242-76-5050 89 Director May 12, 1919 North Carolina Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a. State show the Medical Examiner must be notified at Director 1 ☐ Yes 2 No 28a-f MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò death with 20910 23a USA 2201 Colston Drive, Apt. #308 Funeral or items, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White þ 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event "because." Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Caleb Samuel McCurdy Lena Ella Hudson ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gideon L. Lang / Husband 2201 Colston Drive, Apt. #308, Silver Spring, MD 20910 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cemetery Mar. 18, 2009 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. Mullaucharner 500 University Blvd. West, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death One Week Immediate Cause (Final Stroke **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atrial Fibrillation 3 months Sequentially list conditions, if any, leading to immediate cause. Cluse as or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760. physician Physician/Medical aftending pl IF FEMALE yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) ☐Yes 2XXNo Ö the detached 9 Ulnknown ۵. ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 H Unknown page 2 should Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The certificate 1 ∐Yes 2 🔀 No 1 ☐ Yes 2 🛛 No Be (25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital 1 Yes 2XXNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred After To the Hospitar or within 24 hours after death.
To the Funeral Director: Aft 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28656 February 27, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15225 Shady Grove Rd., Suite #208, Rockville, MD 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 3 Day 2009 Year **Physician** Derrickson Paul Littleton 7:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 8257 Bethards Rd. Berlin Worcester Birthplace (State or Foreign Country)
 MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year 9/23/1940 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 🔀 M 2 🗆 F 68 Yrs MD 221-28-0121 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show ns 23a or 28a-f shor 1 ☐ Yes 2√☐ No Director MD Worcester Berlin 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8257 Bethards Rd. 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 XNever Married 2 Married 9 1 ☐ Yes 2 X No Specify \$ Specify: white 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farming 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental 27 is marked of traumatic evi Ralph Littleton Belva Bethards ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) f of Health 8206 Bethards Rd., Berlin, MD 21811 Department of Health Important: If item 27 any injury or other tr Kitty Littleton 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. 3/2/2009 Frankford, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Mille MIHS /Medical Examiner 4/25 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No g Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2X☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 ☐ Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5X Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours after To the Funeral Dire Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D/0658 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Maryland 21215-0036

altimore.

Box 68760.

P.O.

Division of Vital Records,

400 EHSTERN SHOKE DUNNE

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Barry E. Lofland County of Death 4b. City_Town, or Location of Death Facility Name (If not institution, give street and number) SOUY DICE OF If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year Date of Birth (Month, Day, Year) 01/24/1953 Birthplace (State or Foreign Country) Social Security Number Sex 11 M 2□ F 56 Months Days Hours Min. 215-62-0827 Delaware Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Wicomico Hebron Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21830 8834 Olde Florist Lane USA 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates: Army Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married 1 ☐ Yes 2 XNo Specify: Specify white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) clerk convenience store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Virginia Hastings Charles Lofland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theodolinda Lofland/wife 8834 Olde Florist Lane, Hebron, MD 21830 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/27/09 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Kell R 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final MRTASTATIC disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to infined at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Due to (or as a consequence of): IF FEMALE: 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 🗆 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 4 🔲 Pregnant at time of death ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes → No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 2. THO 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence Other (Specify) / CSPIC/2 21 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 27. Marmer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural Natural 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

The law requires that the death certificate be executed P.O. Division of Vital Records, Physician:

Box 68760,

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Certification:

Medical

29a. Certifier

permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marical Examples and the retified at

Physician

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Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir To the Hospital or Attending State Registrar

WAN 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COAS 710

and manner stated.

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

10058410

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

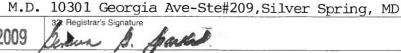
Amend #5 per Fh g891 5/26/09 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 19^{Day} 2009^{Ye ar} **Physician** Feb. 2140 Maiden James Paul /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Nov. 18, 1941 9. Birthplace (State or Foreign **Funeral** Days 1 🕱 M 2 🗆 F 67 Virginia 227-4-4042 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Medical Evanter must be notified at once. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11901 Georgia Ave. 20902 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc 1 Never Married 2 X Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No 2 Yes. Give Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Paul Maiden Annie Lee ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anntoinette Haskins/Daughter 8605 11th Avenue Silver Springs, MD 20903 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lincoln Memorial 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Feb. 25,2009 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility A. Sanders & Sons Mortuary 21. Signature of Funeral Service Licensee P.O. Box 25124 ALexandria, VA 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician THERU ONTIAL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Director for an airconscinence offs Examine e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Penneral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uniknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of RECURRENT autopsy performed CHOLE CYSTITI 1 ☐ Yes 2 ☐ No 1 □Yes 2 □No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)
MAR 0 3 2009

Anuradha Arun,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



2009

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Funeral Director Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show may Injury or other traumatic event, If a Madical Experiment be notified at once. Baltimore, Maryland 21215-0036

Physician /Medica Examine

For State Registrar

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, Θ

		1. Decedent's Name	e (First, Midd	lle, Last)							2. Date of Dea				3. Time o	of Death		
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ŭ	4	17. Father's Name	(First, Middle,	L . Last)							e (First, Middle,	Maiden :						
Be	4	David Mey		,					G	ertrude	Hecht		,					
욘	1	10a Informant's Na	ame/Relations	shin (Tyne Pri	nt)		19b Mailii	na Address (St	et and N	Number or Bur	al Route Numbe	r City o	Town St	ate Zin	Code)			
	19a. Informant's Name/Relationship (Type. Print) Ruth H. Meyer, wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 3301 North Leisure World Boulevard #431 Silver Spring, Maryland 20906											31	, 6000)					
	20a. Method of Disposition 20b. Place of Disposition (Name of complete view place) 20c. Location - City of complete view place)												y or To	wn, State				
		1 ☐ Burial 2 ☑ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery, ciematory or other place) National Crematorium 2/27/2009 Falls Church, Virginia												inia				
i	f	21. Signature of Fu	ineral Service	Licensee		50						TTON	737		<u> </u>	11114		
	21. Signature of Funeral Service Licenses 564 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 Rockville Pike, Rockville, Mary													;. ·v1a	ınd 2	0852		
	1	23a. Part 1. Enter t	he disease, o	r complication:	s that caus	ne death	. Do not ent	er the mode of	dying, su	ch as cardiac	or respiratory ar	est,	, 1101		Approxima	te		
0	1	23a. Part 1. Enter the disease, or complications that caus and e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each die. Approximate Interval Between Onset and Death Onset a																
		disease or condition resulting in death) Bladder Cancer Due to (or as a consequence of):											rs					
r																		
ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury																	
Ë	Cause. (Disease or injury that initiated events c																	
Examiner	c. Due to (or as a consequence of):																	
g				L d	d													
cian/Medical																		
2		IF FEMALE: 23b. Was decedent	t pregnant		es, outcome			7 =				2	3d. Date o	of delivery				
icia	23b. Was decedent pregnant 1															Year		
Physic	9 Unknown 9 Unknown																	
<u>δ</u>		Part II. Other signif	ficant conditi	lons contributii	ng to death bu	ut not resu	ılting in the u	nderlying cause	given in	Part I.	23e. Did to	bacco u	se contribu	ite to th	ne cause of	death?		
Completed by											1 □ Y	es 2[] No 3	☐ Prob	ably 4 🔼	Unknown		
ete											24a. Was a		24b. We	re auto	psy findings	available		
Į											autop perfor	med?	dea	4b. Were autopsy findings available prior to completion of cause of death?				
Be	-	25. Was case refer	red to medica	al T					26	Place of Deat	1 ☐ Yes h (Check only or	2 XN 0	1 L	Yes	2 🗆 No			
		examiner? 1 ☐ Yes 2 🛣		Hospita	l: 1 □ Inpatie	ent 2∏	ER/Outpatie	nt 3 DOA	044		me 5 XResid		□Other	(Snacif	(v)			
ĮĖ.	1	27. Manner of Deat		288	. Date of Inju	ry	28b. Time o		njury at Vork?		28d. Describe h			(Specii)	у/			
işi		1 X Natural 2 ☐ Accident	5 Pendii invest	ng igation	(Month, Day	y, rear)	Injury	М	Vork? □Yes	2 No								
iji		- 3 ☐ Suicide	6 Could		. Place of Inju	ıry - At ho	me, farm, str	eet, factory, offi	ce		28f. Location (S	treet and	d Number	or Rura	l Route Nur	nber,		
ert		4 Homicide	20.011		building, etc	. (Specify	()				City or Tow	n, State)						
<u>a</u>	1	29a. Certifier									and due to the							
Medical Certification: To		(Check only one)	2□ Medica	I Examiner: O ar	n the basis of nd manner sta	f examinat	tion and/or ir	vestigation, in	ny opinio	n, death occur	red at the time, o	late and	place, and	due to	the cause(s)		
Ž																		
1	d	(N/.0)	1eur	à m.2					D319	18	I	ebr	uary	26,	2009			
	-	30. Name and addr				eath (Item	23a) (Type,	Print)										
		Dr. Warre							B1vd	l, Silv	er Sprin	ng, l	Mary1	and	2090	06		
State		31. Date filed (Mon			32 Registra													

Registrar

MAR 03

			For State	State of Maryland	•				- 2 n n q	08392		
			Registrar 1. Decedent's Name (First, Middle, Las	:t)		tificate of D	eatn	2, Date of Death	3. Time of Death			
	Physicia /Medic		Almira	Mar	hne			Month 2	2 ¹ 8 200	7 1645 M		
	Examin	er	4a. Facility Name (If not institution, give	,		4b. City, Town, or Le			4c. County of Dea			
	Funeral Director		Montgomery Gener 5. Social Security Number 6. Social Security Number	ex 7. Age (In yrs. la:	st birthday) Yrs.	Olne If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) Co	thplace (State or Foreign ountry)		
			212-02-3709 Usual Residence of Decedent	92				Dec. 14,	1916] P	eru		
	yland how		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits		
	e Mar la-fs	당	Maryland	Montgomery	Roc	ckville				1 ☐ Yes 2 🔼 No		
	or 35	Director	10e. Street and Number			10f. Zip Code		109	g. Citizen of What Co	ountry?		
	ath w	<u>a</u>	90 Monroe Stree			20850			USA			
0000	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. He first stranked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3€3 Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of Hisp fYes, specify Cuban, ⊠Yes 2 □ No	panic Origin? (Spo Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.) Peruvian	14. Race - Ame Black, Whit Specify: W			
0-017	thin 72 hou ie. ian "natura Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	lent's Usual Occupati kind of work done dur OO NOT use retired)			6b. Kind of Business	/Industry		
7	ed wi	ပ္ပ	. 12		Hon	nemaker			Own Hom	e		
2	be fill ntal H sd oth even	Be	17. Father's Name (First, Middle, Last)			1:		(First, Middle, Ma	,			
<u>X</u>	nould d Mer narke natic	မ	Jose Aguilar		Olorteg							
, Ma	and 2 st ealth an T 27 is r ner traur		19a. Informant's Name/Relationship (7 Berta Sarria/Dau	ghter	e, Silve	Route Number, City or Town, State, Zip Code) e, Silver Spring, MD 20						
5	permit. Pages 1 and 2: Department of Health a Important; If item 27 is any injury or other trau		20a. Method of Disposition 1	Hemoval from State	_	sition (Name of natory or other place) Ieaven Cem	eterv ^{Ma}	rch 5	oc. Location - City or ilver Spr	Town, State ing, Maryland		
חשו	permit. Page Department of Important; If any injury or once.		21. Signature of Funeral Service Licen:	see Tale	Fr 50	Name and Address ancis J. O Univers	of Facility Collins	Funeral	Home Inc. lver Spri	ng, MD 20901		
	Physician /Medical	65 Y	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each line. Hypoxic Encer Due to (or as a conseque	Do not ente	er the mode of dying,				Approximate Interval Between Onset and Death		
	cate be executed which is the burial-transit and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	Attending Prysicians, the law requires that the death certifics of death. Telebr. After this certificate has been signed by the attending phey the funeral director, page 2 should be detached for use as the funeral director.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₺ No 9 □ Unknown	23c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	death 3 □	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year		
- (cp	fuires tnat n signed b	φ	Part II. Other significant conditions of Hypertension, Di	-	23e. Did tobacco use contribute to the cause of deat 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unkn							
מו חבכט	sictant: The taw fequir certificate has been s rector, page 2 should	Completed				autopsy prior to completion of cause of performed? death?						
=	nysician; nis certific director,	Be	25. Was case referred to medical examiner?	Hospital:		Othor		(Check only one)	•			
5 8	Pny rrthis ral di	: To	1 Yes 2 ₩ No	1 1 Inpatient 2 L E	R/Outpatien 28b. Time of	28c. Injury a	4 LI Nursing no		ce 6 Other (Spe	cify)		
5	th. th. tane	tjo	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury	Work?	s 2 □No	28d. Describe how injury occurred				
	after dea after dea Director Director	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	Street and Number or Rural Route Number, wn, State)			
	To the rospital or Attending Private in the Funeral Director: After the completely filled in by the funeral	edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	ysician: To the best of my knowl iner: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the time restigation, in my opin	, date and place, nion, death occurr	and due to the cau	use(s) and manner a e and place, and due	s stated. to the cause(s)		
	withir Somp	Me	29b. Signature and title of certifier	well	Mr	29c. License n	D26540		d. Date signed (Monte ebruary 28			
7			30. Name and address of person who concern Schoenberge	ompleted cause of death (Item 2 r, MD 16220 I	23a) (Type, F reder	Print)	Gaither	sburg, M	D 20877			
	Sta Registra		31. Date filed (Month, Day, Year) MAR 0.3 200	32 Registrar's Signatur	re four	KI						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08393 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 12:18a M Leroy Martin 25-2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year May 5, 1947 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours ntry) SC XXM 2□ F Yrs **Director** 578-64-3650 61 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f short 1 Yes 2 □ No Director PGBrentwood MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20722 USA 4405 39th ST Funeral Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ② No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or items 11. Marital Status 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes XXNo ۾ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Coilege (1-4or 5+) Elementary/Secondary (0-12) Mechanical Engineer McDonalds Corporation 2yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Lattimore Preston Martin ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health and Paulette C. Martin/wife 4405 39th ST Brentwood, MD 20722 Department of Heall Important: If item 2 any Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-2-2009 Ft. Lincoln cem. Brentwood, MD 22. Name and Address of Facility Marshalls Funeral Home of Funeral Service Licensee 21. Signatul 4217 9th ST NW Washington, DC 20011 Approximate Interval Between Onset and Death used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Pa . Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): sician and burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. phys attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 | Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 2 □ No Пyes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □Yes 1 ☐ Yes 2 ☐ No 2 HNO 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann f Death 28c. Injury at Work? Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death. filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d

To the Funeral Direct
completely filled in by determined 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal To th. within 24 (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of mpleted cause of death (Item 23a) (Type, Print) Name and address of person who c

Registrar
DHMH 17 Rev 1/2001

State

37. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery 8. Date of Birth Month, Day Year) 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months Days 517-22-8272 1**⊠**M 2□F 81 Butte, Montana Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified or once. 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Montgomery Rockville 1 ☐ Yes 2 XNo Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6121 Montrose Road 20852 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 1942-1945 Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Ş White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Real Estate Broker Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ed Marans Fritzie Marans 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Beth Marans -Daughter 5204 Baltimore Avenue Bethesda, Maryland 20816 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Garden of Remembrance 2/27/2009 Clarksburg, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Bonald V. Borgwardt Funeral Home, PA Wonal 4400 Powder Mill Road Beltsville, Maryland 20705 or 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician s the burial Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 2 No I or Attending Physician: after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: ို 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. r of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 / Natural Injury To the Hospital or Autenances within 24 hours after death.

To the Funeral Director: Aft 1 Yes 2 □ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state

□ (Check only one) 29b. Signature and title of certifie 0 ROSERD, ROCKVILLE, MD 20852

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State Registrar 31. Date filed (Month, Day,

Year.

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 08395 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician Tema Ruth Mason** 2009 February 3:58 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Port Republic Calvert 1650 Grays Road If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🖾 F Months Days 66 Yrs Director 215-38-4982 Maryland July 10, 1942 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Examinations to cother traumatic event, Ite Medical Examinations. 10b. County Director 1 ☐Yes 2 XNo MD Calvert Port Republic 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **USA** Funeral 1650 Grays Road 20676 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Tes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔼 No Specify ۾ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teaching Elementary School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ဂ McKinley Johnson Sara Gross 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1650 Grays Road, Port Republic, MD 20676 Glenn Mason - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brooks UMC Cemetery 3/3/2009 St Leonard, MD 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility Bladys a. Sewell Funeral Home, P.A., 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician end /Medical Due to (or as a con-uence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) I ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director; After this certificate I completely filled in by the funeral director, page 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Catherine Brophy, 10845 Town Center BIVD # 203, Dunkirk, MD 20754 W 31. Date filed (Month, Day, Year) 32. Registral's Signature State Registrar 2009

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			For State Registrar		State	of Ma	aryland		artment of I				giene Reg. Ne	\circ)	083	96
	. D	9	1. Decedent's Name (First, Middle, Last) 2. Date of Death													3. Time of I	
	Physic /Medi		Edna		MacDonald							March	March 2 200		ar	11:50	АМ
	Exami	ner	4a. Facility Name (. 0	,			4b. City, Town, o		of Death			. County of D			
	Funeral		5. Social Security N		6. Sex	7. Age	(In yrs. la	ast birthday)	_ If Under 1 Year	If Under		8. Date of Birt	- 1		Birthola	ace (State of	r Foreign
	Director		100-16-7428 1□M 2MF 91			1	Yrs.	Months Days	Hours	Min.	8. Date of Birl (Month, Da 04/04/	1917	N	Counti 11SC	onsin		
	land ow		Usual Residence o 10a. State	10b. County			10c. City,	, Town or Lo	cation						10	d. Inside City	y Limits
	Mary a-f she	ţċ	Maryland	Wico	mico		Sal	lisbur	У							1X Yes	2 🗆 No
	ith the	Funeral Director	10e. Street and Nu						10f. Zip Code					izen of What	Counti	y?	
	eath v	eral	900 Boot	th St.	12 Was I	Decedent E	ver in II S	13 \	2180.		rigin? (Sn	ecify Ves or No.		SA 14. Race - A	merica	n Indian	
92	hours after death with the Maryland hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	y Fun	1 □ Never Marr		Arme	d Forces? es 2 ½ N , Give or Dates:			Was Decedent of H If Yes, specify Cub 1 □ Yes 2 🛣 No			Rican, etc.)		Black, W	/hite, e		
Š	2 hour attural	Completed by		15. Decedent	's Education			16a. Deced	dent's Usual Occup	oation		- +1	16b. K	ind of Busine			
215	thin 72 e. an "na Media	nplet	Elementary/Seco		t grade complet	<i>ed)</i> je (1-4or 5-	+)		kind of work done DO NOT use retire		st of work	ing				·	
25	iled wi		12 17 Father's Name	(First Middle	l ast)			adını	nistrato		ar'e Name	e (First Middle		lic so	noo	ı syst	:em
San	uld be f Mental I Irked ol	To Be	17. Father's Name (First, Middle, Last) Edward Bernds 18. Mother's Name (First, Middle, Maiden Surname) Susan Tyndall														
Meryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type. Print) Bruce MacDonald/son 19b. Mailing Address (Street and Number or Rural Route Number, City, or Town, State, Zip Code) 4564 MacArthur Blvd.N.W., Washington, DC 20007										7				
Edna	it of He	1 5	20a. Method of Dis	•	3 □Removal fr	om State			sition (Name of matory or other pla			Date		ocation - City			
Edna	nit. Pa artmer ortant: injury		4 ☐ Donation 21. Signature of Fu	5 ☐ Other (Spuneral Service L			Sal		Cremato		3/3/		-	lisbury			
77 6	Departiment once.		1 Kee	8KX	curey	(F5)	P	T	Name and Addre Holloway 501 Snow	Funer Hill	Rd.,	lome Pro Salisb	fess ury	sional , MD 2	Ass 1804	sociat 1	ion
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	Examiner				b.	to (or as a	conseque	ence or).									
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	execute	Examiner	that initiated events resulting in death) I	S	c	to (or as a	conseque	ence of):							+		
8760	cate be executed oblysician and the burial-transit				d												
g	leath certifice attending ph	/Med	IF FEMALE:		23c. If yes,	outcome r	of pregnan	10V					1				
Box	death e atten	Physician/Medical	23b. Was deceden in the past 12 1 \(\superscript{Yes}\) 2 [months?	1 ☐ Li 4 ☐ Pi	ve birth 2 regnant at t	2 🗌 Fetal (death 3□]Ectopic pregnanc] Other <i>(specify)</i> _	y				23d. Date of o Month			ear
0	that the de ned by the	Phys	9 □ Unknown	n e		nknown	h h 1	Al a series allows				1 00 000					
Division or Vital Becords.	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by										Did tobacco use contribute to the cause of death? ☐ Yes 2☐ No 3☐ Probably 4☐ Unknown					
Seco	e law re has be	Completed										24a. Was a	SV	_ prior t	to comp	sy findings av	vailable use of
70	siclan: The law s certificate has b lirector, page 2 s		25. Was case refer	red to medical						00 51	45	1□ Yes		death 1 🗆 Y			
5	Physiclan: r this certifica	To Be	examiner?		Hospital: 1	☐ Inpatien	nt 2□E	R/Outpatien	t 3 DOA Oth			n <i>(Check only oi</i> me 5□Resid		6 ∏Other (S	necify)		
0	ding Ph n. After thi funeral	on: T	27. Mann of Deat	th 5 Pending	28a. D	ate of Injury Month, Day	v :	28b. Time of Injury				28d. Describe h			peenyy	-	
Sio	I or Attending after death. Director: After d in by the fune	icati	2 ☐ Accident 3 ☐ Suicide	investiga 6 ☐ Could n	ation ot be	ace of injur	ry - At hom	no farm stre	M 1 □	Yes 2		28f. Location (S		od Alexandra	D 1.4	Do 14 - 87 - 117	
D	tal or A rs after al Dire	Certification:	4 Homicide	determi	ned bi	uilding, etc.	(Specify)		out, rustory, office			City or Tow	n, State)	nurai i	ioute Numb	er,
	To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one)	1 ☑ Certifying 2 ☐ Medical F	Examiner: On th	the best of ne basis of nanner stat	examination	ledge, death on and/or inv	occurred at the tivestigation, in my	me, date ar opinion, dea	nd place, ath occuri	and due to the or	ause(s) date and	and manner d place, and c	as stat	ed. he cause(s)	
	Vithi To tl	Ž	29b. Signature and	title of certifier	,	_			29c. Licens			2	29d. Dat	te signed (Mo	onth, Da	ay, Year)	
	5		- W//	aher	will	1	MD	20-1 /=	D	603	15		5	12/00	1.		
	8U		30. Name and addr Mahesh		who completed c arayapp				Print) ternshor	e Dr	Sal	isbury l	MD 2	1804			
	Sta Registi		31. Date filed (Mon	MAR 0 3	2009	2. degistrar	r's Signatu		arks								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Patricia Smith Nolan 25, February 2009 10:53 a^M 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney Montgomery 8. Date of Birth (Month, Day, Year) June 26, 1 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 036-24-5090 Months Days Hours Min 1 □ M 2 🗗 F 71 1937 Rhode Island Usual Residence of Decedent 10b. Count 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15430 Bramblewood Drive 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. White Specify: 3x Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Litigation Professional Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leo Francis Smith Mary Frances Hunt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Nolan, III/Son 18308 Dundonnell Way, Olney, MD 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State March 2, Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 Silver Spring, Maryland 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd,. W., Silver Spring, MD 2090 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pulmonary Edema Due to (or as a consequence of) Coronary Atherosclerosis Sequentially list conditions if any, leading to minimum cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Diabetes Mellitus, Type II Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension, Hyperlipidemia 1 ☐ Yes 2 D No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy 1 ☐ Yes 2 🖾 No

Physician /Medical Examiner

Physician

/Medical

10a State

Examiner

Funeral

Director

28a-f show

iral", or items 23a or 28a-f shov Examiner must be notified at

"natural"

d other than "nature event, the Medical

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Nem 27 is marked other than "ray injury or other traumatic event, IT MAY once.

Director

Funeral

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Completed

Be

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the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

burial-tran

Hospital or Attending Physician: The law requires that the death certificate be executed and physician the as attending p ed by the been signed be should be deta has page 2 certificate this nours after death.

neral Director: After the filled in by the funeral

of Vital Records, P.O. Box 68760,

Division

Examine Physician/Medical \$ Completed Be

Certification: To

Medical

State Registrar IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2001No

3 ☐ Suicide

29a. Certifier

4 Homicide

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 X ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 2 Accident

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number 40063234 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

weadt D.0 8 31. Date filed (Month, Day, Year)

6 ☐ Could not be

24 hours a

To the within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** March nn IVE /Medical 4a. Fecility Name (If not institution, give street and number County of Death **Examiner** Washington 134 Sunflower Drive Hagerstown If Under 1 Year | If Under 24 Hrs 6. Sex 1 ▲ 2 □ F 8. Date of Birth (Month, Day, Year) March 20, 1933 Pennsylvania Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Hours 75 190-26-1885 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturat", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21740 HSA 134 Sunflower Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 1951- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces 1 XYes 2 ☐ If Yes, Give Year or Dates: Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🗓 No Specify: <u>م</u> 1954 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engine Tester Truck Manufacturer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth O'Brien Nicholson Mae Oliver Peter 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21740 134 Sunflower Drive Hagerstown, Maryland Patricia J. Nicholson - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State 2 Cremation 1 🛛 Burial 3 🗆 R 4 □ Donation o ☐ Other (Specify Mar.7,2009 Williamsport, Maryland Greenlawn Mem. Park 21. Signature of Funeral Service OSBOTALA POR EFET Home, P.A. 21795 Maryland 425 S. Conococheague St. Williamsport, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interva! Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mone Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner and resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23d. Date of delivery Year Month Day use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No has

Physician /Medical Examiner certificate be executed Division or Vital Records, P.O. Box 68760,

with the Maryland

Baltimore, Maryland 21215-0036

I or Attending Physician: after death. Director: After this certifica

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ⊟Ectopic pregnancy 5 ☐ Other (specify)		23d. Date o Month
Atheroscle	contributing to death but not resulting in			use contribu
Chronic pr Hypertens			24a. Was an autopsy performed?	24b. We prid dea 1 L
25. Was case referred to medical		26. Plac	e of Death (Check only one)	
examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Ou	tpatient 3 DOA Other: 4 N	lursing Home Residence	6 □Other
27. Manner of Death		Time of 28c. Injury at Work?	28d. Describe how injur	y occurred

Chro
HUPE
25. Was case ref examiner? 1 ☐ Yes 21
27. Manner of De
2 Accident
3 ☐ Suicide 4 ☐ Homicide

Be

2

Medical

ral 5 Pending investigation dent 6 ☐ Could not be ide

М

1 Yes 2 No 28e. Place of injury - At home, ferm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

6 ☐Other (Specify)

29a.	Certifier (Check only
	one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and tile of certifier		,
1 / Lanna		
1 July	0	۰

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DH 5+1

To the Hospital or within 24 hours aft To the Funeral Di

State Registrar

MAR 06

ampus Rd 56

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 27, 2009 **Physician** Estelle S. Oresky 1:45P. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Hillhaven Nursing Home Prince George's Adelphi 8. Date of Birth Month, Pay 1924 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 100-14-5170 1 ☐ M 2 🔀 F 85 Yrs. New York Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Maryland Prince George's Adelphi 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 8105 New Riggs Road 20783 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No White Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Julius Stone Jennie Koplik 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8105 New Riggs Road Adelphi, Maryland 20783 Seymour M. Oresky -husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Mt. Lebanon Cemetery 3/2/2009 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death WEEKS Immediate Cause (Final **Physician** disease or condition resulting in death) Aspiration Pneumonia /Medical Due to (or as a consequence of) Examiner Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last vears Examine Due to for as a nonsequence of burial-transit Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2√2 No 9 ☐ Unknown Year 4□Pregnant at time of death 5 ☐ Other (specify) is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Osteoporosis; Dementia; Chronic renal insufficiency 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24a. Was an cate has page 2 s autopsy perform After this certificate funeral director, pag 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical

To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division or Vital Records,

29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number D19609

Fel. 27- 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tuli,M.D. 10810 Dərnestown Rd.,#202 Gəithersburg, Mərylənd 20878 Rəmən R.

State Registrar 31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-01650 State of Maryland / Department of Health and Mental Hygiene Erma M. Okoro Certificate of Death 1- For State Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day February 25, 2009 1857 hrs Erma M. Okoro Medical Examine 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Adelphi 3403 Chatham Road 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 7. Age (In yrs. last birthday) 5. Social Security Number Funeral oreign CountrWirginia Months Days 61 Oct.21,1947 Director 2 X F 223-64-1445 1 M Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 No s 23a or 28a-f show a notified at once. Maryland Prince George's Adelphi permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other remanaite event, the Diedical Examiner must be nollfred at once injury or other remanaite event, the Diedical Examiner must be nollfred at once Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20783 3403 Chatham Road 14 Race - American Indian, Black. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11 Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 2 X Married 1 Never Married .Yes African American Yes 2 X No specify: If Yes, Give Year 4 Divorced á 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Accounting Firm Management Baltimore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Florence E. Calloway Clarence Douglas Miller Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ۵ (Husband) 3403 Chatham Road Adelphi, Maryland 20783 Abdolhossein Aghabozorgi 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition MD National Mem. Park 2/28/2009 1 X Burial 2 Cremation 3 Removal from State Laurel, Maryland Donation 5 Other Specify 21. Signature of Funeral Service Licensee Bonard Adress Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on Death **ledical** Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and - transi Physician/Medical AMENDED ned by the attending physician detached for use as the burial -UNPENDED the Hospital or Attending Physician: The law requires that the death certificate be him 24 hours after death. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. within 24 hours after death.

To the Funeral Director: After this certificate has been signed by i completely filled in by the funeral director, page 2 should be defach. Division of Vital Records, P.O. Ś 1 Yes 2 No 3 Probably 4 🗸 Unknown Diabetes Mellitus Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? Yes 2 V No Yes 2 No 26 Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: Residence 6 V Other: Scene DOA Nursing Home 5 Inpatient 2 ER/Outpatient 3 1 🗸 Yes No 28d, Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27 Manner of Death Certification: 1 V Natural Yes 2 No Pending Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 1 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 February 26, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Russell Alexander MD. Assistant Medical Examiner 37. Registrar's Signature 31. Date filed (Mo State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Walter Willson O'Connell 2009 March 2:00 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Coffman Nursing Home Hagerstown Washington County 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday, **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 214-16-0610 1 XM 2 ☐ F Director 99 Aug. 4,1909 Alabama Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shor othar traumatic event, the Medical Experient must be notified at Director Maryland Washington County Hagerstown 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1304 Pennsylvania Ave. 21742 U.S.A. Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 →Widowed 4 □ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Salesman Liquior Wholesaler permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event, ORDS. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Charles O'Connell, II 2 Mary Julia Willson O'Connell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel M. O'Connell-son 10801 Crystal Falls Rd. Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery 3-9-2009 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagertown, MD 21742 23a. Part1. Enter the disease, er complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Dowell **Physician** disease or condition resulting in death) lell /Medical Due to (or as a consequence of): **Examiner** Dequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attanding Physician: The law requires that the death certificate be executed the burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth ∠ □ roca 3-2 4 Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 2 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Jursing Home 5 Residence 6 Other (Specify) this 27. Mann Death 28a. Date of Injury (Month, Day Year) After Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. | Diractor: / 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number completed cause of death (Item 23a) (Type, Print) Name and address 5 m STRET 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryla		artment of F rtificate of I			0.0	09	08402
			Registrar Decedent's Name (First, Middle, Last)		tinicate of t	Dealii	2. Date of De	- 6-9	00	3. Time of Death
~	Physici /Medio		ALICE LOUISE PERSON	1		.=	FEB.	23, 2	0 0 9 gr	0459 M
	Examir	er	4a. Facility Name (If not institution, give street and number) Genesis Health Care Ce	ntor	, ,	r Location of Death er Spri		4c. County	of Death VTGOM	(PDV
	Funeral		5. Social Security Number 6. Sex 7. Age (In)	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		rth		ace (State or Foreign
ļ.	Director		214-42-4546 1	7 Yrs.	Working Days	Tiours Will.	Dec.1	9,1941	Mar	yland
	yland how			. City, Town or Lo	cation				10	d. Inside City Limits
	Ba-f s	Director	MD Montgomery	A:	shton					1⊈Yes 2□No
	with th		10e. Street and Number 1120 Tucker Lane		10f. Zip Code	861		10g. Citizen of \	What Count	ry?
	death	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	n U.S. 13. \	Was Decedent of H		pecify Yes or No	o- 14. Rac	ce - America	
36	be filed within 72 hours after death with the Maryland that Hygiene. d other than "natural", or items 23a or 28a-f show event, the Pedical Exercites out to incitify of	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		il Tes, specily Cuba 1 ⊡Yes 2 _x No	Specify:	nican, etc.)		ck, White, et $y: \ \mathrm{Bla}$	
2-0036	72 hou natura tical E		15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup	ation	ring	16b. Kind of B		
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1d 2	filed of Hygir	Be Cc	2 yrs 17. Father's Name (First, Middle, Last)		omputer	18. Mother's Nam	e (First, Middle,	Inte		
ylar	should be ind Mental marked o	To B	Edwin Gilmore Hill			Lula	a Mae	Jones		
Maryland 21	2 2 2 2		19ā. Informant's Name/Relationship (Type. Print) Lula Mae Hill (Mother)	I	ng Address <i>(Street i</i>					,
	s 1 and of Health item 27 other to			b. Place of Dispos		- 1	Date	20c. Location -		
Baltimore,	Pages ment of ant: If its ury or o		Donation 5 □Other (Specify) 1 □ Burial 2 □ Cremation 3 □ Removal from State G	late of	Heaven	Cem 3/	·		and a	ing,MD
Ball	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Line See	/ //	Name and Address 46 N. Wa					E, P.A. ID 20850
			28a. Part 1. Enter the disease, or complications that caused the di shock, or heart failure. List only one cause on each line.	eath Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
4	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Atrial Due to (or as a cons		llation					Onset and Death
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	led isit	iner	Sequentially list conditions, if my leading to immediate cause. Enter Underlying Cause (Disease or injury			-			- 1	
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08/PU	ificate be executed g physician and is the burial-transit	edical	d							
Ž	certific ding p	/Mec	IF FEMALE: 23c. If yes, outcome of pre-	egnancy	75%					
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Ţ.	that the ned by detacl	/ Phy	Part II. Other significant conditions contributing to death but not r	resulting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use cont	ribute to the	cause of death?
SDJ	en sign	ed by	Respiratory Failure;	Lung Z	Abcess		1 🗆 1	Yes 2□ No	3 ☐ Probal	bly 4 X ∪nknown
Records,	law re has be e 2 sho	Completed	Diabetes Mellitus; H	yperter	nsion		24a. Was	osy	Were autops	sy findings available pletion of cause of
Vitalir	n: The ificate or, pag	e Co	Dysphagia; Stroke; L 25. Was case referred to medical	upus			1 □Yes	rmed?	death? 1 □ Yes 2	
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VISION OI	ding Pt h. After tf funeral	tion:	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year, 2 Accident investigation	28b. Time of Injury	28c. Injury Work			now injury occurr		
NIVIS.	To the Hospital or Attending Physician: The law within 24 Hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or	Certification: To	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - Al building, etc. (Spe	t home, farm, stre ecify)		162 2 1140	28f. Location (8 City or Tov	Street and Numb vn, State)	er or Rural I	Route Number,
	he Hospit in 24 hours he Funera oletely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my leading to the basis of examiner and manner stated.	knowledge, death nination and/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and madate and place, a	anner as sta and due to t	ited. he cause(s)
	Withi To the	ž	29b. Signature and title of certifier H. D.		29c. License			29d. Date signed		
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dav Year Month Leorelary John H. Padgett 2009 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Lanham Prince George's 5. Social Security Number 6. Sex If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Sept. 14, 1925 Takona Park, Maryland 7. Age (In vrs. last birthday) **Funeral** 1 **∏** M 2 □ F Days Hours Min. 218-20-1241 83 Director Usual Residence of Decedent 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Eventrals at must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Berwyn Heights 1X Yes 2□No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8902 59th Avenue 20740 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Gas Station 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Lester Eugene Padgett Gwendoline Mary Ferrar ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna S. Padgett -wife 8902 59th Avenue Berwyn Heights, Maryland 20740 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State George Washington Cem. 2/28/2009 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ^{22, Name and Address of Facility} Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 21. Signature of Funeral Service Licensee Honald 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) neumone 2 wce /Medical Due to (or as a consequence of): Examiner tructive Pul honic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown contributing to death out hot resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2 No 2□No 25. Was case referred to medical examiner? filled in by the funeral director, Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2XNo 1XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

P.O. Box 68760, Division of Vital Records,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

State Registrar (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year)

D26492

2.26.09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4000 Mitchellville Rd. Bowie, MD 207/6

Registrar's Signature

and manner stated.

T

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			For State Registrar	State of Maryl		rtment of F			iene eg. No. 2009	08404								
ľ	Physici		1. Decedent's Name (First, Middle, Last) Ilva Parsons					2. Date of Dea Month		3. Time of Death 8:10 PM M								
	/Medi Examir		4a. Facility Name (If not institution, give so			Salisbury		1	4c. County of Dea	ath								
	Funeral Director		5. Social Security Number 224-14-8091 Usual Residence of Decedent	7. Age (In	yrs. last birthday) 2 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) 05/19/1	, Year)	rthplace (State or Foreign country) ginia								
	he Maryland 28a-f show otified at	ector	10a. State 10b. County Maryland Wicomico	100	City, Town or Loc	ry				10d. Inside City Limits 1 ☑ Yes 2 ☐ No								
	ath with t s 23a or 2 sust be n	Funeral Director	10e. Street and Number 900 Booth St.	·		10f. Zip Code 21801			0g. Citizen of What C									
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the Medical Examiner must be notified at once.	d by Fune	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒Widowed 4 □ Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Vas Decedent of F f Yes, specify Cub ☐ Yes 2🎛 No	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh Specify:									
Maryland 21215-0036	d within 72 h giene. r than "natu the Medical	Completed by	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give life. E	ent's Usual Occup kind of work done OO NOT use retired	oation during most of wor d)	king	16b. Kind of Business									
and	d be filed ental Hyg ced othe c event,	Be	17. Father's Name (First, Middle, Last) Samuel A. Taylor					ne (First, Middle, I										
Mary	nd 2 shoul Ith and Ma 27 Is marl traumati	၉ -	۲	ř	19a. Informant's Name/Relationship (Typ Don Richardson/a	,				ıral Route Number	; City or Town, State, ID 21801	Zip Code)						
Baltimore,	Pages 1 ar nent of Hea nt: If Item 3		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State	b. Place of Dispos cemetery, cren	natory or other plac	ce) 3/2,		20c. Location - City o									
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Livense		22	Name and Addre	Funeral Hill Rd.	Home Pro	fessional ury, MD 21	Association .804								
	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart fallure. List only one Immediate Cause (Final disease or condition resulting in death)	ation, that caused the conse on each line.	eath. Do not ente	er the mode of dylin	ng, such as cardiac		est,	Approximate Interval Between Onset and Death								
	Examiner	<u>-</u>		Due to (or as a con														
8760,	cate be executed ohysician and the burial-transit	dical	ysician/Medical Examiner	Physician/Medical Examiner	ical Examiner	ical Examine	Ш	ical Examine	ical Examiner	Ш	Sequentially list conditions, if any, battery to transcribe cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a con						
O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit				IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	c. If yes, outcome pf pre 1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)	/		23d. Date of de Month	elivery Day Year						
rds, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions cont	ibuting to death but not	resulting in the un				Did tobacco use contribute to the cause of death?									
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Division or	ing Affei une	Certification: 1	27. Manur of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Yea.				28d. Describe ha	w injury occurred									
Divi	r te r		4 Homicide determined	28e. Place of injury - A building, etc. (Sp				City or Town										
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	sian: To the best of my er: On the basis of exan and manner stated.	knowledge, death nination and/or inv	occurred at the tire estigation, in my c	me, date and place ppinion, death occu	, and due to the ca rred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)								
	To t To t	Σ	29b. Signature and title of certifier	15	111	29c. Licens		29	9d. Date signed (Mon	th, Day, Year)								
•	2501		30. Name and address of person who com	pleted cause of death (Item 23a) (Type, F		605/5		120/09	A								
	Sta	te.	Mahesha Thimmarayappa 31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	Dr Salis	bury MD 218	304										
	Registr		MAR 0 3 200	19 Senera	B. 14	arke												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** neophilus 2115 Nii Armah /Medical 4a. Facility Name (It not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel P.G aurel Regional If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Quantry) 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** 10XM 2□F Months Days Yrs NONE Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ire Incident Expringer must be notified a once. 1 Ves 2 □ No **Funeral Director** aurel MID Trince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Street 115A 20707 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: If Yes, Give Year or Dates: ģ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) None None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Theophilus Akwelei ဂ Rlina 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Codd) Selina Mother 264 Laurel, HD 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo Laurel 4 □ Donation 5 ○ Other (Specify) Company 21. Signature of Funeral Service Licensee O 22. Name and Address of Facility 17 c Ito sprt 120 Vand-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PREMATURETY - EGA 22 Was by PHYCICAL MATURETY EXTREME DIGO LATHA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death. Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) _ Ö 9 Unknown 03 03 2009 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ EXTREME REMATURITY 1 ☐ Yes 2 🗙 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Hospital: 1 Yes 2 No Certification: To 1 Mainpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 XNatural 1 ☐Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DOO47415 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wisconsin Avenue, Suite 406 Bethesda, MD 20814 Sunday Uchella, MD 7900 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			1 - State Registrar AVFND#24a/bperMD3/6/09, EMW, MbCb	Cert	ificate of l	Death			Reg. No.	009	00400
Ī	Physici		1. Decedent's Name <i>(First, Middle,</i> Last) Leelamma Helen Ressalam					2. Date of Dea Month February	Day	Year 2009	3. Time of Death 1:13 a M
way.	/Medio Examir		4a. Facility Name (If not institution, give street and number)	4	4b. City, Town, or	r Location		rebruary		inty of Death	1
أرب			Washington Adventist Hospital		Та	akoma	Park			Montgo	mery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	h v Year)	9. Birth	nplace (State or Foreign
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	sath v	eral	10712 Cherry Tree Court 11 Marital Status 12. Was Decedent Ever in U.S.	12 1/4	as Decedent of H	20783	isin2 /Cna	oifu Voo or No	14		S.A.
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a fired fex a classified at once.	/ Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give	If Y	as Decedent of A Yes, specify Cuba ⊒Yes 2⊠ No	an, Mexical Specify:	n, Puerto F	Rican, etc.)		Race - Ameri Black, White,	
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			shock, or heart failure. List only one cause on each line.		the mode of dyin	ig, such as	cardiac or	r respiratory as	rest,		Approximate
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DHMH 17 Rev 1/2001

State Registrar Daniel Alexander,

31. Date filed (Month, Day, Year)

M.D.

32 Registrar's Signature

12700 Goodloes Promise Dr, Bowie, MD 20720

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08408 Reg. No.2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death ^D26, 2009 **Physician** February Edith RATZKIN 6:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth

Adopths | Days | Hours | Min. | Jan. 28, 1918 Hebrew Home of Greater Washington Montgomery 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign i. Social Security Numbe 579-10-1329 **Funeral** 1 □ M 2 📝 F New York 91 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits r items 23a or 28a-f shov iner must be notified at Director 1 ☐ Yes 2 ☑ No Maryland Montgomery Potomac permit. Pages 1 and 2 should be filed within 72 hours after death with the 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-any injury or other traumatic event, it a Medical Exp. uner must be notified once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9013 Cherbourg Drive 20854 United States Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white ģ Specify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob Spector Pauline Weintraub ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Ratzkin, Son 9013 Cherbourg Drive, Potomac, MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 02/27/09 20c. Location - City or Town, State 1 Burial 2 Cremation 3 K Removal from State King David Memorial Garden Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 23a. Part 1. The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): burial-transi resulting in death) Last Due to (or as a consequence of): physician a the burial 68760 Physician/Medical attending philon at the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mont Month Dav Year 5 Other (specify) P.0. the detached 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ٥ 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate l performed' Division of Vital 1 □ Yes 2 - No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Certification: To After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 Natural thin 24 hours after death.

the Funeral Director: A propletely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To th within 2. (Check only 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

854

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Pebruary 27, 2009 Szabo Louise 4:15 a M Rose 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bedford Court Skilled Nursing Center Silver Spring Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Gountry | Trance | Trance | France 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 1 F 238-60-2846 79 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3202 Gleneagles Drive 20906 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Specify: White 1 ☐ Yes 2 XNo Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Accountant Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theophile Hugon Adeleine Emilima 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexander Andrew Szabo/Husband 3202 Gleneagles Drive, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State March 6, 4 ☐ Donation 5 ☐ Other (Specify) 2009 Norbeck Memorial Park Olney, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility. Francis J. Collins Funeral Home Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Spindle-Cell Cancer of Spine with Metastatic Disease 8 months Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) □Yes g Unknown g ☐ Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

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Box 68760

P.O.

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Division or Attending Examiner

Physician/Medical

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Certification: To

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?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the literal Examiner must be notified at

e filed within 72 hours after death all Hygiene.

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Department of Health at
Important: If Item 27 Is
any Injury or other trau

3altimore, Maryland 21215-0036

the Maryland show

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

Parkinson's Disease

24a. Was an

autopsy performe 1 ∐Yes 2 TxNo 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes

25. Was case referred to medical examiner? 1 Tes 2 No

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 5 Pending

28b. Time of 28c. Injury at Work? Injury 1 □Yes 2 □No

Other: 4* Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 XNatural 2 Accident 3 Suicide 4 ☐ Homicide

27. Manner of Death

investigation 6 Could not be determined

2009

Hospital:

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

nd title of certi 29b. Signature

29c. License number D18726 29d. Date signed (Month, Day, Year) February 27, 2009

Name and address of person who completed cause of death (Item 23a) (Type, Print)
Apthur Schoengold, MD 18111 Prince Philip Drive, Olney, MD 20832 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear **Physician** Ronald W. Sweenev , 2009 5318 AM rebruari 27 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Lanham Doctors Community Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year July9,1926 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Days Months 82 Washington, DC 578-30-2733 Director Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits show Department of Health and Mental Hygiene, important; if item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, Ira Medical Examinat must be notified at once. 1 Yes 2 □ No Director Maryland Prince George's Greenbelt death with the 10f. Zîp Code 10g. Citizen of What Country? 10e. Street and Number 116 Greenbill Road 20770 United States Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1944-1946 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married 3altimore, Maryland $^{\prime\prime}$ 21 $^{\prime}$ 215-0036 1 □Yes 2 No White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Facilities Specialist N.S.A. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary C. Brodrick Edward A. Sweeney ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 116 Greenbill Road Greenbelt, Maryland 20770 Patricia A. Sweeney -wife 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 Metropolitan Crematory 2/28/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEART DISEASE Physician ATHERSSELENSTL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Genen.Co bearsolen ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 C Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 HInknown icate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 ☐ Unknown 1 🗌 Yes 2 🔲 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy performed res 2 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 9

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Brian S. Bayly, MD

31. Date filed (Month, Day, Year)

000 23586

7223 Hanover Parkway, SuiteB Greenbeit, MD. 20170

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 25, 2009 Flora SINGER **Physician** 10:40 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 8217 Lakenheath Way Po toma c 8. Date of Birth (Month, Day, Year)
Aug. 16, 1930 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign Months 1 M 2 XF 082-24-1945 78 Belgium Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Director Maryland Montgomery Po toma c 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 8217 Lakenheath Way 20854 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify: þ white Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name_(First, Middle, Maiden Surname) David Mendelowitz Fani Genut 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Landsman, Daughter 12217 Lake Potomac Terrace, Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Judean Memorial Gardens 03/01/09 21. Signature of Funera 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Days Immediate Cause (Final Congestive Heart Failure disease or condition resulting in death) Due to (or as a consequence of): Cerebral Vascular Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its total autors.) Examiner Due to (or as a consequence of): Years Hypertension resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 4 ☐ Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 2 No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be

Box 68760, P.0. of Vital Division

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, for Medical Evantment be notified at

Physician

Examiner

/Medical

Maryland

Baltimore,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar 4 Homicide

29b. Signature and title of dertifier

29a. Certifier

Medical

ddress of person who completed cause of death (Item 23a) (Type, Print) M.D., 5454 Wisconsin Ave., #925, Chevy Chase, MD Joseph A. Vassallo, 31. Date filed (Month, Day, Year) Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 33844

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

February 26, 2009

20815

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

09-01558 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Patricia Anne Simmons State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death Physician/ Month Day February 22, 2009 Medical Examiner PATRICIA ANN SIMMONS-KELLY 1225 hrs 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Montgomery General Hospital Olney Montgomery 5. Social Security Number If Under 1 Year If Under 24Hrs 8: Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Hours Foreign Director 128-48-1393 Sept. 12, 1956 Country) 52 M 2X F Usual Residence of Decedent 10a State 10c. City, Town or Location 10d Inside City Limits MD Montgomerv Rockville 1 Xyes 2 28a-f show notified at once, with the Maryland Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 431 College Parkway 20850 U.S.A. 238 Funeral 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, ě death Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Never Married 2 X Married Yes 2X No 0 frimore, MD 21215-0036

it. Pages 1 and 2 should be filed within 72 hours after definition of Health and Montal Hygions urdant: If item 27 is marked other than "natural", or yor other traumatic event, the Abdictal Examinor un yor other traumatic event, the Abdictal Examinor un Black after Give Yea Widowed Specify Divorced Yes 2 X No specify: þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Holland & Knight Elementary/Secondary (0-12) College (1-4 or 5+) 2 yrs Legal Secretary Law Firm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earnest Simmons, Be Earnell L. Shuler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 2 1 19a. Informant's Name/Relationship (Type, Print) 4301 Akins Ridge Ln, Powder Springs, GA Arthur L. Simmons (Brother) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date ltimore, crematory or other place 1 X Burial 2 Cremation 3 Removal from State Gate of 3/5/09 Silver Spring, MD Heaven Cem nent lant: or of nation 5 Other Spe 22. Name and Address of Facility SNOWDEN FUNERAL HOME. 246 N. Washington St, Rockville, MD 2085 Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death a. Gunshot Wounds (2) of Torso Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Fetal death Day Year past 12 months? Pregnant at time of death Yes 2 No 9 ✓ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was ar 24b. Were autopsy findings available autopsy prior to completion of cause of page 2 s performed? death? ✓ Yes 2 ~ Yes No 25. Was case referred to medical To the Hospital or Attending Physician: 26 Place of Death (Check only one) Division of Vital Be examiner' Other₄ Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 After this ို 1 V Yes 28a. Date of Injury 27 Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Feb 22, 2009 Subject shot Natural 1130 hrs thours after death. Yes 2 V No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 31 Norwood Road , Silver Spring , MD determined (Specify) Other (church) 4 V Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Funeral within 2. To the F

29b. Signature and title of certifie

Ling Li, MD 31. Date filed (M

State Registrar and manner stated

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner

2 The Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year)

February 23, 2009

Joseph Jerome		1- For State Registrar	e of Maryland /	Departme Certifica			d Mental H	R	200 eg. No.	
Physici Medical Exami		1. Decedent's Name (First, Middle, L JOSEPH	JEROME	SHELTO	N			2. Date of Dea Month March 7, 1		3. Time of Death 0940 hrs
No.		4a. Facility Name (if not institution, 123 East 8th Street, Apa				ty, Town, or ederick	Location of Dear		4c. County of Death	1
Funeral Director		5. Social Security Number 217-54-0269		(In yrs. last birthe		Jnder 1 Year onths Days			rth(MM/DD/YYYY) g. Bir Foreig 17, 1956 Co	
		Usual Residence of Decedent		10c. City, Town o				Journ.	17,11339 %	
Haryland 28a-f show any 1 at once.	'n	MD 10b. County Frede			reder	rick				10d. Inside City Limits 1 X Yes 2 No
death with the Maryland or items 23a or 28a-f shomust be notified at once.	Director	10e. Street and Number			10f.	Zip Code		1	0g. Citizen of What Cou	ntry?
with the	al D	123 East 8th	12. Was Decedent				panic Origin? (-5	Specify Yes or No	U.S.A. 14. Race - Amer	ican Indian, Black,
er death	Funeral	1 Never Married 2 Marri	1 Yes 2	X No			, Mexican, Puerl	o Rican, etc.)	White, etc.	ito
ours afte	۵	Widowed 4 XDivorce 15. Decedent's Education (Specify	ed If Yes, Give Year or Dates: only highest grade com			ual Occupat	ion (Give kind of		Specify: VVII	
36 in 72 ho :. than "n	Completed	Elementary/Secondary (0-12) 9th	College (1-4 or 5	(+)	_	_	. DO NOT use re ployed		Renova	tion
5-00 iled with Hygiene I other	Com	17. Father's Name (First, Middle, La	,	}			18.Mother's Nan	ne (First, Middle,	Maiden Surname)	
21215-0036 uld be filed within 7 Montal Hygiene. marked other than	To Be	Edward Garl 19a. Informant's Name/Relationship			Mailing Addr	ress (Stree		i Ruth Rural Route Nur	Witt mber, City or Town, State	e, Zip Code)
MD nd 2 sho alth and m 27 is		Jospeh Edwar	d Shelton	1	.348 W	Veste	rn Cha	pel Rd	, New Wind	dsor,Mb''
nore, ges l ar nt of Hez t: If ite		1 X Burial 2 Cremation	3 Removal from Sta	te cremator	y or other pla	ace)	.	Date /12 /00	20c. Location - City or Woodsbo:	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Montal Hygiene. In prortant: If them 27 is marked other than "matural"; on highery or other traumatic event, the Medical Examiner.		21. Si na re of Funeral Service Lic		MC. I	22. Name a	and Address	of Facility S	NOWDEN	FUNERAL I	HOME, P.A.
m ឧក្ខ័ Physician	7 1	23a. Part I. Enter the dilease, or co	mpfications that caused t	the death. Do not	4		_		•	Approximate Interval
/Medical		failure. List only one cause on Immediate Cause (Final disease	each line. a. Narcotic	,						Between Onset and Death
, Kailinier		or condition resulting in death)	Due to (or as a conse	quence of):						
	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	quence of):						
Ps d e	Exam	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):						
e executed cian and rial - transi	dical	X UNPENDED	daMENDED 23a	,27,28a-	f, per	ME, g	889 3/1	8/09 TT		
Box 68760, e death certificate be execut the attending physician and ed for use as the burial - tra	an/Medical	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	ne of pregnancy	Fetal dea	ath 3	Ectopic pregr	nancv	23d. Date of deliver	y Day Year
OX 6 eath cert	<u>5</u>	past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at	time of death 5	Other (S			,		,
cords, P.O. B. law requires that the de has been signed by the	y Phy	Part II. Other significant condition		but not resulting	in the underly	ying cause g	given in Part I.	23e. Did t	obacco use contribute to	the cause of death?
ls, P. quires then signe and be de	ted by	ļ						. 1Ye . 24a. Was	s 2 No 3 Pro	bably 4 Unknown
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of Vit Physic ter this e	유	examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatier		patient 3 me of Injury		Other Nurs		Residence 6 Othe	r: Scene
ion of Vending Pheath.	ation	1 Natural 5 Pending 2 Accident Investig	(Month, Day, Ye	ear)	•	I '	Yes 2 X No	unk	,.,.,,	
Division of Vital Records, pital or Attending Physician: The law requireral death. eral Director: After this certificate has been silled in by the funeral director, page 2 should the control of the funeral director, page 2 should the funeral director of the funeral director.	Certification:	3 Suicide 6 X Could n	ot be 28e. Place of Inj	ury - At home, far home	m, street, fact	tory, office b	ouilding, etc.	28f. Location (or Town, S Frederi	Street and Number or Ru State) 123 E . 8 CK, MD	ural Route Number, City
프로 등 등 교		29a. Certifier (Check only 1 Certifying Phys	ician: To the best of my	-				nd due to the caus	se(s) and manner as stat	ed.
To the Hos within 24 h To the For	Medical	29b. Signature and title of certifier	ner:On the basis of exam and manner stated.	nination and/or inv		my opinion		at the time, date	and place, and due to the	

State 31. Date filed (1901) Registrar

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

March 8, 2009

Laron Locke MD.

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 16a, b per fh g889 3-27-09 vt
State of Maryland / Department of Health and Mental Hygiene

1 - For State AVEND#23e, 24a, 25, 27pen/D, 3-10-09, BW, M-00
Registrar

Reg. No. 2 0 0 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death Feb. Physician Joseph Thomas, Jr. 22ay 2009 8:27A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Magnolia Nursing Home Lanham If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 1 M M 2 □ F 578-42-8261 Director 76 May 26,1932 Washington, DC Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ir than "natural", or items 23a or 28a-f shov the Wedical Eventimer must be retified at 1XIYes 2 □ No Director Capital Heights MD Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1110 Elfin Avenue 20743 U.S.A. Funeral death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ⊠Yes 2 No If Yes, Give 1951-54 Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Black Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. If Item 27 is marked other than or other traumatic event, the Mental or other traumatic events. Elementary/Secondary (0-12) College (1-4or 5+) Fire Safety Inspector Federal Government 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph James Thomas Susie Wooden ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1110 Elfin Ave. Capitol Heights, MD Audrey L. Thomas/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. March 4,2009 Cheltenham,MD Cheltenham Veterans 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of FM Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility Latney's Funeral, 3831 Georgia Ave. N.W. Wash.D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BLADDER CANCER WITH METASTASIS **Physician** Interoun /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to influediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner Attending Physician: The law requires that the death certificate be executed DM Type 11 .. Jenour ours after death. eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Malnuhihim Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a the Hospital 29a. Certifier 🗠 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 25, 10063978 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20770 7525 GREENWAY CTR DR, GREENBELT, MID SYED IM'D HINA 31. Date filed (Month, Day, Year) Registrar's Signature State 03 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Shady Grove Adventist Hospital Rockville Months Funeral Director Funeral Director Shady Grove Adventist Hospital Rockville Rockville Rockville School Rock Rockville	Pounty of Death Intgomery 9. Birthplace (State or Foreign Country) China 10d. Inside City Limits 1 □ Yes 2 ☒ No en of What Country? an, China 4. Race - American Indian, Black, White, etc. Specify: Asian d of Business/Industry Home
4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital Funeral Director Funeral Director Shady Grove Adventist Hospital Shady Grove Adventist Hospital Funeral Director Funeral Director Shady Grove Adventist Hospital Shady Grove Adventist Hospital Funeral Director Fundant Funeral Director Months Day, Months Day, Months Day, Months Day, Months Day, Months Day, Funeral Months, Months, Months, Months, Day, Funeral Months, Months, Day, Funeral Months, Months, Months, Day, Funeral Months, Months, Day, Funeral Months, Months, Months, Months, Day, Funeral Months, Months, Months, Day, Funeral Months, Months, Day, Funeral Months, Months, Months, Day, Funeral Months, Months, Months, Months, Months, Mo	Pounty of Death Intgomery 9. Birthplace (State or Foreign Country) China 10d. Inside City Limits 1 □ Yes 2 ☒ No en of What Country? an, China 4. Race - American Indian, Black, White, etc. Specify: Asian d of Business/Industry Home
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MD Montgomery Potomac 10e. Street and Number 10g. Citize 12511 Linda View Lane 12g. Citize 12511 Linda View Lane 12g. Citize 12g. Citiz	en of What Country? an, China 4. Race - American Indian, Black, White, etc. Specify: Asian d of Business/Industry Home
10e. Street and Number 12511 Linda View Lane 20854 Taiw. 10f. Zip Code 20854 Taiw. 10g. Citize Taiw. 11g. Was Decedent of Hispanic Origin? (Specify Yes or Nolity Fee Specify Cuban, Mexican, Puerto Rican, etc.) 11g. Marital Status 1g. Was Decedent of Hispanic Origin? (Specify Yes or Nolity Fee Specify Cuban, Mexican, Puerto Rican, etc.) 11g. Marital Status 1g. Was Decedent of Hispanic Origin? (Specify Yes or Nolity Fee Specify Cuban, Mexican, Puerto Rican, etc.) 11g. Marital Status 1g. Was Decedent of Hispanic Origin? (Specify Yes or Nolity Fee Specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent of Hispanic Origin? (Specify Yes or Nolity Fee Specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent of Hispanic Origin? (Specify Yes or Nolity Fee Specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent of Hispanic Origin? (Specify Yes or Nolity Fee Specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent of Hispanic Origin? (Specify Yes or Nolity Fee Specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent of Hispanic Origin? (Specify Yes or Nolity Fee Specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent Specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent Specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent Specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent Specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent Specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent Specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent Specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent	an, China 4. Race - American Indian, Black, White, etc. Specify: Asian d of Business/Industry Home
The state of the s	4. Race - American Indian, Black, White, etc. Specify: Asian d of Business/Industry Home
Short Table 1	d of Business/Industry
(Specify only highest grade completed) College (1-4or 5+) College (1-4or 5+)	Home
No sold the polyment of the po	
Yi Kang Yi Kang Yi Kang 19a. Informant's Name/Relationship (Type. Print) Nina Chow (Daughter) Yi Kang 19b. Mailing Address (Street and Number or Rural Route Number, City or 1) Nina Chow (Daughter) 12511 Linda View Lane Potomac, MI	urnamei
19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Nina Chow (Daughter) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or 12511 Linda View Lane Potomac, MI	arrancy
Nina Chow (Daughter) 12511 Linda View Lane Potomac, M	Town, State, Zip Code)
O - 그 등등 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Loca	D 20854 ation - City or Town, State
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Local cemetery, crematory or other place) 20c. Local cemetery, crematory or other place) 4 Donation 5 Other (Specify) Metropolitan Crem. 2009, Alexa	andria, VA
21. Signature of Funeral Service Licensee Curtus E. Way 22. Name and Address of Facility DeVol Funeral H 10 East Deer Park Dr. Gaithersh	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hypotension	Approximate Interval Between Onset and Death 4 Days
Examiner Due to (or as a consequence of):	1 Week
Sequentially list conditions, if any, leading to immediate cause. Enter Universitying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Bilateral Pneumonia C. Due to (or as a consequence of):	10 Days
of the control of the	1 Month
Pulmonary Embolism Pulmonary Embolism	
23b. Was decedent pregnant in the past 12 months? 1	3d. Date of delivery Month Day Year
Specific by the first of the period of of	e contribute to the cause of death? No 3 Probably 4 Unknown
autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
To the control of th	1 ☐ Yes 2 ☐ No
examiner? Comparison Compa	
27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 1 \(\time{\text{N}}\) Natural 5 \(\text{Pending}\) Pending 2 \(\text{Pending}\) Accident investigation M 1 \(\text{Pending}\) Accident	occurred
5 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Number or Rural Route Number,
29a. Certifier 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) a control of the cause of the caus	
	signed (Month, Day, Year) uary 27, 2009
	20850
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. Sujatha Ramaseshan M.D. 9901 Medical Center DR. Rockville, ME	

DHMH 17 Rev 1/2001

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, in the Medical Exemiter must be notified at angle.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, State Registrar DHMH 17 Rev 1/2001

	For State State Registrar	-	Certificate of i			g. No 2 () () (9 08416				
an	1. Decedent's Name (First, Middle, Last)		<u> </u>		Date of Death Month	Day Ye	3. Time of Death				
al	JOHN AMOR TAL 4a. Facility Name (If not institution, give street and number)	LEY	4h City Town o	Location of Death	FEB	27 200					
er	HARBOR HOSPITAL		4b. City, Town, or Location of Death 8ALTIMORE 4c. County of Death								
	5. Social Security Number 221–26–2144 6. Sex 1 ☑ M 2 ☐ F 67	(In yrs. last birth	nday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 11/08/1	9. 941	Birthplace (State or Foreign Country) Maryland				
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits				
tor	Maryland Wicomico	Salis	sbury				1 X Yes 2 No				
I Direc	10e. Street and Number 309 South Haven Ave.		10f. Zip Code 2186	04	10	g. Citizen of What	t Country?				
Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced 12. Was Decedent Endred Forces? 1 Yes 2 No lif Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cuba 1 □Yes 2☑No		ecify Yes or No- Rican, etc.)		American Indian, /hite, etc. white				
eted	15. Decedent's Education (Specify only highest grade completed)	16a. E	Decedent's Usual Occup	ation Juring most of works	ina 1	6b. Kind of Busine	ess/Industry				
mpl	Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done of life. DO NOT use retired)	h-100-0-0-	es ai sa					
ပ္ပ	12 4		announcer	18. Mother's Name		harness :	racing				
To Be	John M. Talley				ice Barl	, , , , , , , , , , , , , , , , , , , ,					
-	19a. Informant's Name/Relationship (Type. Print) Christina Talley/daughter	196. !	Mailing Address (Street 309 S. Have	and Number or Run	al Route Number, alisbury	City or Town, Sta	te, Zip Code)				
	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State		Disposition (Name of crematory or other place	200-		Oc. Location - City					
	4 Donation 5 Other (Specify) Salisbury Crematory 3/5/09 Salisbury, MD 21. Signature of Feneral Service Licenses Professional Association										
	Holloway Funeral Home Professional A 501 Snow Hill Rd., Salisbury, MD 21										
	23a. Part 1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line immediate Cause (Final disease or condition resulting in death) a. Due to (or as a	€.		g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death				
er	Sequentially list conditions, if any, leading to immediate Due to (or as a										
Ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or mighty that initiated events c						4				
dedical Examiner	resulting in death) Last Due to (or as a consequence of):										
Medi	IF FEMALE:										
Completed by Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	/	23d. Date of delivery Month Day Year						
A P	Part II. Other significant conditions contributing to death but	t not resulting in t	the underlying cause give	en in Part I.	23e. Did toba	acco use contribut	e to the cause of death?				
d b	END STAGE RENAL DISEASE 1 Yes 2 No 3 PI										
omplete	MORBID OBESITY	AFI	BRILLA	TION	24a. Was an autopsy perform	ed⊘ i deat					
BeC	25. Was case referred to medical examiner?			26. Place of Death	1 ☐ Yes 2		Yes 2 □ No				
	Hospital:	nt 2 ER/Outp	patient 3 DOA Oth	er: 4 🗆 Nursing Ho	me 5 Resider	ice 6 Other (5	Specify)				
.: O	27. Manner of Death 1 Matural 5 ☐ Pending 28a. Date of Injury (Month, Day,	y 28b. Tir Year) Inj	me of 28c. Injur ury Worl	y at	28d. Describe hov	injury occurred					
ificati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injur	ry - At home, farn	M 1 □	Yes 2 □No	28f. Location (Stre	eet and Number o	r Rural Route Number,				
Cer	Vi				City or Town,	•					
Medical Certification: To	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of 2 ☐ Medical Examiner: On the basis of and manner stat	examination and	death occurred at the till or investigation, in my c	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manne te and place, and	er as stated. due to the cause(s)				
Σ	29b. Signature and title of certifier MD		29c. Licens	e number		d. Date signed (M					
	30. Name and address of person who completed cause of de			ED CT							
te	JEET CANDHI 300 31. Date filed (Month, Day, Year) 32. Registrat			VER 51 K	B	ACILMO	RE MD-2122				
ar	MAR 0 3 2009 Sense	m B.	park								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 02105AM 2009 Dominique Alizabeth Whittaker /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington County Washington County Hospital Hagerstown | Months | Days | Hours | Min. | Month, Day, Year) | Hous | A6 | MArch 2, 20 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🛣 F 2009 |Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County "natural", or items 23a or 28a-f show 1 ☐ Yes 2 ☐ No Maryland | Washington County Hagerstown Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Mydical Examinat must be no once. U.S.A. 21742 302 B. North Colonial Dr. Funeral 12. Was Decedent Ever In U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1. Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Black Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Taylor Whittaker Derek Whittaker ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sarah Whittaker-mother 302 B. North Colonial Dr. Hagerstown, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 3-3-2009 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg, Maryland Smithsburg Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pouglas A. Fiery Funeral Home 21. Signature of Funeral Service License 1331 Eastern Blvd. North Hagerstown, MD 21742 19 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** rema disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 2 🕡 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manuar of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 / Natural 5 ☐ Pending investigation n 24 hours after death. le Funeral Director; Aft bletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

State

31. Date filed (Month, Day, Year)

MAR 0 6 2009

6h

Andrew

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes

,			1 - For State Registrar	State of Ma	aryianu /	-	tificate of		ına iviei		eg. No.	2009	08418	
	Physici	an	1. Decedent's Name (First, Middle, La	•					2.	Date of Deat	th Day	Year	3. Time of Death	
1	/Medi		Matilda Elizabet							Month 3	1	1 2009 2:00 p ^M		
	Examir	ner	4a. Facility Name (If not institution, given 12004 Turtle Mil				4b. City, Town, o		Death	4c. County of Death Worcester				
	Funeral		Social Security Number 6. 8	Sex 7. Ag	e (In yrs. last	birthday)	If Under 1 Year Months Days	If Under 2	24 Hrs. 8. Min. 6	Date of Birth Month Day			nplace (State or Foreign	
	Director		215-12-6/36 12 W 241 88 Yrs.							/1/192	0 0		MD	
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	ation						10d. Inside City Limits	
	e Mary	ctor	MD Worces	ter	Bish	opvil	lle						1 □Yes 2 🛛 No	
	/ith the	Dire	10e. Street and Number	1 01			10f. Zip Code			1		zen of What Cou	untry?	
	eath v	eral	12004 Turtle Mil	1 KQ.	Ever in I.I.S.	12 1/4	21813	lienanie Oria	in? /Specifi	Vac or No		USA 14. Race - Amer	iona Indian	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the McGoal Evanting could be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Xillimored 4 Divorced	Armed Forces? 1 □ Yes 2 X If Yes, Give Year or Dates:			fas Decedent of H Yes, specify Cuba □Yes 2 X No		Puerto Ric	an, etc.)		Black, White		
5-0	72 hc	etec	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	10	6a. Decede	ent's Usual Occup ind of work done o O NOT use retired	ation during most o	of working	16b. Kind of Busine			ndustry	
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d 2	e filed al Hygi other /ent, I	Be C	17. Father's Name (First, Middle, Last)			,,,,,	18. Mother	's Name <i>(Fi</i>	irst, Middle, N	Maiden S			
ylar	ould be I Mental narked c	욘	William Gordon							y Lee				
Maryland	12 sho hand 7 Ism traum		19a. Informant's Name/Relationship (William G. Wilki		I .		Address (Street							
	thealthem 27		20a. Method of Disposition	115, 11 / 5	20b. Place		ition (Name of atory or other place		Date		<u>-</u>	cation - City or T		
E C	Pages nent of I unt: If Ite		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif				atory or other plac Cemetery		/6/20	09	Rer1	lin, MD	,	
Baltimore,	permit. Departm Importa any Inju		21. Signatura of Funeral Service Licer		1-1-51-3	22.	Name and Addre	ss of Facility	Bu	rbage	Fune	eral Hon	ne	
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-	/Medical Examiner		resulting in death)	Due to (or as	a consequenc	ce of):		0	1				4	
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60,	be exelician a		resulting in death) Last	Due to (or as	a consequenc	ce of):								
68760,	rificate be executed by physician and as the burial-transit	Medical		, d										
Вох	eath certi attending for use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnanc				2:	3d. Date of deliv	very	
О. В	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/	in the past 12 months? 1 □Yes 2 ⅓ No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown			Other (specify)	у				Month	Day Year	
٩.	that the		Part II. Other significant conditions of	ontributing to death b	ut not resulting	esulting in the underlying cause given in Part I. 23					acco us	se contribute to	the cause of death?	
Records,	quires in sign uld be	d by							_	1	s 2 🖸	⊋No 3⊟ Pro	bably 4 🗆 Unknown	
၀၁	e ław require has been si e 2 should b	Completed								24a. Was ar		24b. Were aut	opsy findings available	
Ä	The cate has	Som							_	autopsy perform 1 🗆 Yes 2	ned?	prior to co death? 1 ☐ Yes	ompletion of cause of 2 □ No	
Vital	slcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	0 P1		heck only one				
ð	Phys er this eral dir	٦: T	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatie	nt 2 ☐ ER/6	Outpatient o. Time of	3 ☐ DOA Othe	4 LI Nurs		5 Reside		Other (Special	ify)	
ion	Attending P death. ctor: After y the funer	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	y, Year)	Injury	Work	ໃ?ື່ Yes 2 ∐ No		DOGGNIDO NO	· · · · · · · · · · · · · · · · · · ·	Socured		
Division		Certification: To	3 ☐ Suicide 6 ☐ Could not be determined		ury - At home, c. (Specify)	farm, stree	et, factory, office		28f.	Location (Str City or Town	eet and State)	Number or Rur	al Route Number,	
Ω	pital o		200 Cortifier 1 Contituing Di	unicials. To the best	of many languages	lana alamaka								
	To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b	Medical	(Check only 2 Medical Exar	nysician: To the best on the basis of and manner sta	f examination	and/or inve	estigation, in my o	pinion, death	n occurred a	at the time, da	ause(s) ate and p	and manner as place, and due t	stated. to the cause(s)	
	vit co	2	29b. Signature and title of certifier	13.			29c. License	e number		29	d. Date	e signed (Month,	Day, Year)	
			30. Name and address of person who	completed cause of d	eath (Item 22s	a) (Type Pr	rint)	12 68	7		5	5/07		
į	ET 30		314 Frontin	Are Su	te 4	63	Berlin	MO	21	811				
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					,	Certificate	Ü.	eath		F	neg. N2. 0 0	9 08	3419
	LE		1. Decedent's Name (First, Middle, Las	<i>t</i>)						2. Date of Dea Month	Day	Year	ime of Death
	Physiciar /Medica		JOHN CALV	IN WII	MBROL	V					y 26 Z		30
	Examine		4a Fecility Name (If not institution, give	street and number)						cation of Death			
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	Funeral		Sociel Security Number 6. Security Number	DKM 2016	e (In yrs. last bir	Months	Year Days		Min.	8. Date of Birtl (Month, Day	r, Yeer)	9. Birthplace (S Country)	
	Director		229 36 4864	77	7	Yrs.				SEPT, 01	1931	VIRGIN	110
	pu »	ŀ	Usuel Residence of Decedent 10a. Stete 10b. County		10c. City, Town	n or Location						10d. Ins	side City Limits
	aho a	5										1 5	¥Yes 2□No
	the N	2	VIRGINIA RCCOMAC	: K	CHINO	101. Zip 0					10g. Citizen of W	/het Country?	
	ath with the Maryland s 23a or 28a-f show met be notified at	5		0.4 0.0 4				7/			USA	19	
	eath	runeral Director	5343 MCLEA.	12. Was Decedent B		13. Was Decede	ent of I	Hispanic Or	igin? (Spe	ecify Yes or No-	14. Race	e - American Ind	lian,
	ter dea	5	1 ☐ Never Merried 2 ☐ Married	Armed Forces? 1 M Yes 2 □ N		If Yes, specif	ly Cub	an, Mexica	n, Puerto	Rican, etc.)	Blac	k, White, etc.	
8	ars aft	2	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	28 No	Specify:			Specify.	WHITE	4
21215-0020			15. Decedent's Ed	ucation	16a.	Decedent's Usual (Give kind of work	Occup	pation	et of worki	na	16b. Kind of Bu		
2	c 🚟	Completed	(Specify only highest grades) Elementery/Secondary (0-12)	College (1-4or 5	+)	life. DO NOT use	retire	d)		9			
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ng	単三ち	8	17. Father's Name (First, Middle, Last)					1 - 1			Maiden Surnam		
Na Na	Mental Mental urked o	-	DOUGLAS PA	RKER L							VENN		
Baltimore, Maryland	and and seum	1	19a. Informent's Name/Relationship (7			. Mailing Address							1
	s 1 and f Health frem 27 other tr	-	JAY WIMBROW			7946 A Disposition (Name		ANS	ROL	Date	20c. Location -		
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			23a. Pert1. Enter the diseese, or comp shock, or heart tailure. List only	olications that caused	the death. Do	not enter the mode	of dy	ing, such as	cardiac o	or respiratory ar	rest,	Interv	oximate val Between
1	Physician				7							Onse	et and Death
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ă	requiras that the daath certificate be executed seen signed by the attending physician and should be datached for use as the burial-transit	Physician	Pert II. Other significant conditions of	potributing to death h	ut not resulting i	n the underlying ca	use di	iven in Pert	I.	23b. Did 1	obacco use cor	ntribute to the c	ceuse of death?
P.0	that the da	Ş	Total agimount obtained	y moderning to occur or		, , , , , , , , , , , , , , , , , , , ,	10			10	Yes 2□ No	3 Probably	4 Unknown
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r Sp.	v requiras been sign should be	ed by								24a. Was	an autopsy med?	24b. Were au	
ပ္ပ	law recias bee	Ē									/	completi of death?	ion of cause ?
of Vital Records,	The law ata has page 2	Completed								101	res al No	1 ☐ Yes	2∏-No
ta	iclan: The I certificata ha rector, page	Pe C	25. Was case referred to medical					26. Plac	e ef Deatl	h (Check only o	ne)		
\leq	Physician: this certific ral director,	0	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 ER/O	utpatient 3 DO	A O	ther: 4MN	ursing Ho	me 5 ☐ Resid	dence 6 Oth	er (Specify)	
	g Phy er thi		27. Manner of Deeth	28a. Dete of Inju (Month, De	ry (28b.	Time of 28	Bc. Inju	ury et ork?		28d. Describe I	now injury occur	red	
Ö	Attending in death. Sctor: After by the fune		1 V Naturel 5 ☐ Pending 2 ☐ Accident investigetion	1	,,	М	1[Yes 2					
Division	ar de ecto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injusting, etc.	ury - At home, fa c. (Specify)	arm, street, factory,	, office			28f. Location (S City or Tox	Street and Numb vn, Stete)	er or Rural Roul	te Number,
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	100		30. Name and eddress of person who	completed cause of d	leath (Item 23a)	(Type, Print)	W A	1 511	WE	DW.	Alicai	MY AAD	71804
			31. Dete filed (Month, Day, Year)	32. Registr	ar's Signature	-1/1/6/	CFV	21701	CE	VICI I	AUSBU	1 1011	7-7
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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Ella R. Wade 8:55 PM M 2009 February 26 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Wicomico Nursing Home Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Age (In yrs. last birthday) Months Hours Days 1 ☐ M 2 🔀 F 220-32-9465 101 08/02/1907 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Wicomico Salisbury Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 USA 206 Phillip Morris Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: white 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) sales department store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ella R. Miller William M. Batton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 Phillip Morris Dr., Salisbury, MD 21804 19a. Informant's Name/Relationship (Type. Print) Thomas Wade/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Wicomico Memorial 3/3/09 Salisbury, MD 4 Donation 5 ☐ Other (Specify) Park 21. Signature of Funeral Service Lice Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 menths? Month 5 Other (specify) 1 ☐ Yes 21 ☐ No 9 ☐ Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

iral", or items 23a or 28a-f shov Examiner must be notifled at

"natural"

permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturany Injury or other traumatic event, the Medical

death

Baltimore, Maryland 21215-0036

Director

<u>}</u>

Completed

Be

Examine physician and s the burial-trans attending physical been signed by the should be detached s certificate has b lirector, page 2 s director,

The law requires that the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

or Attending Physician:

To the Hospital

within 24 hours after death.

To the Funeral Director: After this

Physician/Medical Completed by Be

25. Was case referre o medical examiner? Certification: To 27. Mannel of Death filled in by the funeral

IF FEMALE: Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably

24a. Was an performed 1☐ Yes 2 No 26. Place of Death (Check only one)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of Injury 28c. Injury at Work? (Month, Day Year, Injury

왠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Yes 2 No Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

20 No

1 Tes

1 Watural

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only

29c. License number

29d. Date signed (Month. Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mahesha Thimmarayappa M.D. 614 Easternshore Dr Salisbury MD 21804 31. Date filed (Month, Day, Year)

State Registrar

Medical

MAR 0 3 2009

5 ☐ Pending investigation

6 Could not be determined

32 Registrar's Signature

09-01995 Daniel Whittaker Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		- For State	Certific	cate of	Death		Reg.	No.	009 084
Physicia	n/	Decedent's Name (First, Middle,Last)				172 61	2. Date of Death Month D	ay Year	3. Time of Death
edical Examin		Daniel	David	- 12	Whittak		March 10, 20	4c. County of D	
	H	4a. Facility Name (if not institution, give street 110 Altamount Terrace	and number)	41	Cumberland,			Allegany	eau
Funeral	7	5. Social Security Number 6. Sex	7. Age (In yrs. last b	irthday)	If Under 1 Year	If Under 24Hrs	8. Date of Birth (MM/DD/YYYY) 9.	Birthplace (State or breign Kentucky
Director		218-56-6597 1XM 2	F 55	Yrs.	Months Days	Hours Min.	11/04/		Country)
×	- 1-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Locatio	'n				10d. Inside City Limits
ow any		MD Allega			 mberland				1 X Yes 2 No
faryland 28a-f show 1 at once	핡	10e. Street and Number			10f. Zip Code		10g	Citizen of What	Country?
he Mai 1 or 28	Director	110 Altamont Ter	race		215	502		USA	
			as Decedent Ever in U.S. med Forces?		Decedent of Hisps s, specify Cuban,			14. Race - A White, et	merican Indian, Black,
r death	Funeral	1 1	Yes 2 X No		Yes 2 X No		,	Specify:	White
rs afte	ᇫ	3 Widowed 4 Divorced If Yes, or Date 15. Decedent's Education (Specify only high	S:		s Usual Occupation		work done 1	6b. Kind of Busine	
2 hour	leted		llege (1-4 or 5+)	during mo	st of working life. [DO NOT use reti	red)	-1 -	
5-0036 led within 72 Hygiene. other than	Comple	12	24	Lai	oorer			Railr	oad
5-0 led w Hygie I othe	Ŝ	17. Father's Name (First, Middle, Last)				_	(First, Middle, Ma		7.71
2121 2121 ould be fi Mental marked ic event,	o Be	Peter 19a. Informant's Name/Relationship (Type, Pr	J	Whitt		Jean	Stra Rural Route Numbe	atton er City or Town. S	White
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filted within 72 Department of Health and Mental Hygiene. Important: Utiem 27 is marked other than injury or other traumatic event, the Medical	ř	Peter A. Whittaker	The state of the s		,		nham, MD		, , , ,
and 2 and 2 lealth item 2	-	20a. Method of Disposition	20b. Plac		tion (Name of cem			20c. Location - Cir	ty or Town, State
nor ages l at of l		1 X Burial 2 Cremation 3 Report 4 Donation 5 Other Specify:			. Cemete:	ry 03/	14/2009	Cumberl	and, MD
Baltimore, permit. Pages I are Department of Hee Important: If ite Injury or other tr	h	21 S nature of Funeral Savice Licensee	/						al flome, F.A.
E.F. P. B.	_	The & ulam	<u> </u>				et, Cumbe		ID 21502 Approximate Interval
Physician /Medical		23a. Part L Enter the disease, or complication failure. List only one cause on each line					or respiratory arres	t, snock, or near	Between Onset and Death
xaminer		miniculate duese (i iiidi aireada	pertensive ca	irdiov	ascular	disease	-		200
		Sequentially list conditions, b	(6. 6. 6. 6. 6. 6. 6. 6. 6. 6. 6. 6. 6. 6						
	iner	if any, leading to immediate cause. Enter Underlying Cause	(or as a consequence of):						-
	Examin	(Disease or injury that initiated C.	(or as a consequence of):		· ·				-
68760, certificate be executed anding physician and ase as the burial - transit		d	NDED 23a,PII,2	7 202	ME ~000	2/20/09	O dudo		
D, be excision	Medical				ME, goo9	3/20/0	9 11	Lood Bata at da	
876(ifficate ng phy is the b		23b. Was decedent pregnant in the	. If yes, outcome of pregnan Live birth		al death 3	Ectopic pregn	ancy	23d. Date of de Month	Day Year
Sox 687 leath certifi e attending for use as t	ician	past 12 months?	Pregnant at time of death	_ =	ner (Specify)				
BOX he death c	Physi	1 Yes 2 No 9 Unknown g Part II. Other significant conditions contri	Unknown	Iting in the I	nderlying cause gi	iven in Part I.	23e. Did tob	acco use contribu	te to the cause of death?
ires that the signed by a detache	ē	Diabetes mellitus	butting to death but not resul	iting in the c	nidenying added g		ı		Probably 4 V Unknown
ords, **requires s been sig should be	sted						24a. Was ar		re autopsy findings available or to completion of cause of
of Vital Records, g Physician: The law requir wher this certificate has been s meral director, page 2 should	Completed						autops perform 1 Yes 2	ned? dea	ath? Yes 2 No
tal Rec cian: The l certificate l ector, page		25. Was case referred to medical		_	26.Place	of Death (Check			100 2 100
Vital F nysician: this certifi	o Be	examiner? 1 ✓ Yes 2 No	1 Inpatient 2 EF	R/Outpatient	3 DOA	Other Nurs	ng Home 5 R	Residence 6	Other: Scene
	n: ⊢	27. Manner of Death	Ba. Date of Injury 28 (Month, Day,Year)	Bb. Time of I	, ,	y at Work?	28d. Describe ho	ow injury occurred	
ion ttendi leath tor: /	atio	1 X Natural 5 Pending 2 Accident Investigation				'es 2 No			
Division tal or Attendi rs after death al Director: A	Certification:	Suicide Could not be	8e. Place of Injury - At home	e, farm, stre	et, factory, office b	uilding, etc.	or Town, Sta		or Rural Route Number, City
Div Hospital or 24 hours afte Funeral Diu tely filled in		29a. Certifier	o the best of my knowledge,	death occur	red at the time da	te and place, an	d due to the cause	(s) and manner a	s stated.
를 를 를 을	Medical	one) 2 Medical Examiner: On the	e basis of examination and/	or investiga	tion, in my opinion,	, death occurred	at the time, date a	nd place, and due	e to the cause(s)
To You	Me	29b. Signature and title of certifier	nanner stated.		29c. License	e number		29d. Date signed	(Month, Day, Year)
		D-101/11			O.C.1	M.E.		March 11, 20	009
		30. Name and address of person who comple			Bonn Ctrast	Poltimoro N	MD 21201		
			stant Medical Examir 32. Registrar's Signature		Penn Street,	Ballimore, l'	VID 2 1201		
St Regis	ate			1. 60	all				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	•	Certificate of Death	Reg.	2005	08422																
	Physicia	20	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death																
/Medical			SAMUEL JOSEPH			·	0,2009 Year	18:50 м																
	Examin	er	4a. Facility Name (If not institution, give si SOUTHERN MD. HOS	· ·	4b. City, Town, or Location of Dea	I	4c. County of Death PRINCE G																	
۱	Funeral Director		2.0 00 0000 11	M 2□F 7. Age (In yrs. last birth	Months Davs Hours Min		9. Birth 2000 1938 MD.	place (State or Foreign intry)																
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location			10d. Inside City Limits																
	Maryl a-f sho	tor	MD. PRINCE O	EORGES U	PPER MARLBORO			1 □Yes 2 No																
	with the	al Direc	10e. Street and Number 16315 TANYARD F	ROAD	10f. Zip Code 20772		Citizen of What Cou	intry?																
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 _Yes 2 X No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☐ Yos Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Amer Black, White, Specify: WHI	etc.																
21215-0036	thin 72 hc ne. nan "natur Madical	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	completed) I (Decedent's Usual Occupation Give kind of work done during most of wo file. DO NOT use retired) TO A DAMED.	orking	b. Kind of Business/Ir	ndustry																
2	iled wi Hygier ther th nt, It	Co	17. Father's Name (First, Middle, Last)		FARMER 18. Mother's Na	me (First, Middle, Mai	WN FARM den Surname)																	
au	ld be f lental ked ol ic eve	To Be	SAMUEL L. WIN	IDSOR		E BURCH																		
ary	shoul and M s mar	۲	19a. Informant's Name/Relationship (Typ	e. Print) 19b. I	Mailing Address (Street and Number or F	Rural Route Number, C	ity or Town, State, Zi	ip Code)																
% ∑	and 2 lealth m 27 i		GLADYS WINDSOR-		315 TANYARD RD.																			
Baltimore, Maryland	Pages 1 ment of H ant: If itel ury or ott		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State 20b. Place of E cemetery, ST.PE'	Disposition (Name of crematory or other place) PER'S CEMETERY	8-16-09 W																		
Balt	permit. Depart Import any inj	9 15	21. Signature of Funeral Service License	M00479	22. Name and Address of Facility RAYMOND FUNERA LA PLATA, MD. 2	AL SERVIC	E,P.A.																	
Examiner Street be executed The price of t		al Examiner																	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, flary, early to in modern cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	: !:	il In	fiction	Approximate Interval Between Onset and Death
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deli	very Day Year																
	uires tha n signed Id be det	by	Part II. Other significant conditions conf	ributing to death but not resulting in t	he underlying cause given in Part I.		co use contribute to	the cause of death?																
I Records,	The law require ate has been si oage 2 should t	Completed				24a. Was an autopsy performed 1 □ Yes 2 ☑	prior to o death?	opsy findings available ompletion of cause of																
/ita	cian: certific	Be (25. Was case referred to medical examiner?	itali		eath (Check only one)																		
of	Physic rthis ral dire	۲.	1 Yes 2 No	ospital: 1 Inpatient 2 ER/Outp		Home 5 Residence		ify)																
Division of Vital	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification: T	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day, Year) Inj	ury Work? M 1 ☐ Yes 2 ☐ No	28f. Location (Stree	at and Number or Ru	ral Route Number,																
á	pital or ours after eral Dire		4 Hornicide	building, etc. (Specify)	death occurred at the time, date and pla	City or Town, S		stated																
	e Hos 124 hc e Fun	Medical			or investigation, in my opinion, death occurred at the time, date and plate of the investigation, in my opinion, death occurred at the time, date and plate of the time, date and time of time of time of the time, date and time of tim																			
	To th withir To th comp	Me	29b. Signature and title of certifier		29c. License number	29d	Date signed (Month	, Day, Year)																
	i i) li G	ic Modinha	m D 6405	5	05/10/0	4																
			30. Name and address of person who con	npleted cause of death (Item 23a) (T	ype, Print) 29c. License number D 640 5 ype, Print) So. and Hasp. (26,2 for	, md.																	
ij	Sta		31. Date filed (Month, Day, Year)	32. Registrario Signature	A books																			

DX-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year MARCH 10,2009 10:05A ARTHUR OVERTON WOODDY, M.D. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ST.MARY'S CHARLOTTE HALL CHARLOTTE HALL VETERANS HOME If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, AUG . 17 6. Sex Birthplace (State or Foreign Country) Days MD. 93 578-22-2980 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County PORT TOBACCO 1 Yes 2 No MD. CHARLES 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 8340 WOODDY ROAD 20677 12. Was Decedent Ever in U.S. Armed Forces? 1 □ ★es. 2 □ No. NAVY If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 ☐Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) FAMILY PHYSICIAN MEDICAL DOCTOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CLARA HEARD ARTHUR E. WOODDY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOAN WOODDY-SPOUSE 8340 WOODDY RD. PORT TOBACCO, MD. 20677 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT.REST CEMETERY 3-13-09 LA PLATA, MD 21. Signature of Funeral Service Licensee MQ0479 RAYMOND FUNÉRAL SERVICE, P.A. LA PLATA, MD. 20646 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) END STAGE DEMENTIA Due to (or as a consequence of): CORONARY ARTERY DISEASE Due to (or as a consequence of) (HYPERTENSION. Due to (or as a consequence of): CHRONIC RENAL INSUFFICIENCY 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

attending physician and for use as the burial-transi

The law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

or Attending Physician:

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neral Director: Ai
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within 24 hours a

To the Funeral C

completely filled

Examiner

Physician/Medical

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Certification: To Be Completed

Medical

permit. Pages 1
Department of H
Important: If itel
any Injury or otl

Physician

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Funeral

Director

28a-f show

Director

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Completed

27 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examinator must be multilled at

e filed within 7 al Hygiene. I other than "

and 2 should be tealth and Mental m 27 is marked o

72 hours after death

Baltimore, Maryland 21215-0036

/Medical

Scoundary list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed?

1 Tyes

24b. Were autopsy findings available prior to completion of cause of death? 2 DNo 1 Yes

2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death 5 ☐ Pending investigation

6 ☐ Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

CHARLOTTE

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Natural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

> 29c. License number 7067814

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCISCA BRUNEY, 31. Date filed (Month, Day, Year)

29449 CHARLOTTE HALL RD 32. Røgistrar's Signature

Bogsher

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** AM M 7:45 February 2009 Edward S. Adams /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kent 13689 Turners Creek Road Kennedyville 9. Birthplace (State or Foreign Country) Connecticut 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) Dec 23, 1939 5. Social Security Number 6. Sex **Funeral** 1⊠M 2□F Months Days Hours Min. 69 457-64-6858 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show ?7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be neithed at 1 ☐ Yes 2 ☑ No Director MD Kent Kennedyville the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21645 USA 13689 Turners Creek Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 57-61 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white b 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 consultant engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Albert Adams ဥ Jane Lambrych 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar Bonieta Adams/spouse 13689 Turners Creek Road Kennedyville, MD 21645 tem 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Department of Important: If It any Injury or o oonce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Fineral Spice Licensee Wade State Anatomy Board 655 W. Baltimore Street irector Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequ Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical as 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ō Month Day Year 5 Other (specify) ned by the a detached f ☐Yes 2☐No Ö 9 Unknown 9 Unknown σ. II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Be Completed by 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s 1□Yes 🔑 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. 28d. Describe how injury occurred Hospital or Attending Division 1 Natural 2 Accident 5 Pending after death.

I Director: Af d in by the fur 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide e Funeral I 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

Registrar

120 Speer Road

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene? () () 9 08425 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** WILLIAM HENRY BROWN /Medical Town, or Location of Death Facility Name, (If not institution, 4c. County of Death Examiner 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months 1⊠M 2□F MAY 5, ŃC Director 223-52-5245 1943 65 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f shoy Examiner must be notified at 1 X Yes 2 □ No Director BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? items 23a 21202 USA Funeral 1508 HARFORD AVE 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 XNo 1X Never Married 2 Married ō 1 ☐ Yes 2 🛣 No Specify: BLACK Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 ht Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSING CUSTODIAN 6TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ SENIE BROWN JEREMIAH HOWELL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE 1903 BARCLEY ST., MD21218 KELLY McGRAW/NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 XICremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03172009 HANOVER, MD ARDENT 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. Signature of Funeral Service 2007-09 EASTERN AVE., BALTIMORE, MD 21231 s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one can Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician resulting in death) /Medical Du to (or a a consequence of): Pneumonitis Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4⊡Pregnant at time of death 5 ☐ Other (specify) 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 → No 24a. Was an autonsy performed? 2 □ No **1** Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Ž⁄ № Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 npatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral E 1.X ertifying Physician: To the best of any knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier ause of death (Item State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

09-02103 Keon Barnes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 08426 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No Registrar 2. Date of Death Time of Death Decedent's Name (First, Middle,Last) Physician/ Month Day March 14, 2009 1045 hrs Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore University Hospital 9 Birthplace (State of If Under 1 Year If Under 24Hrs. 5. Social Security Number Date of Birth (MM/DD/YYYY) 6. Sex Age (In yrs. last birthday) **Funeral** Foreign Hours Director Country) 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 Yes 2 No or 28a-f show notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Director 10g. Citizen of What Country 10f Zip Code 10e. Street and Number 14 Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status must be White, etc Armed Forces? 1 X Never Married 2 Yes ē If Yes, Give Year Yes 2 X No specify: Specify: Widowed Divorced item 27 is marked other than "natural", traumatic event, the Medical Examiner à or Dates 16a. Decedent's Usual Occupation (Give kind of work done Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 5-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) / Father 19b. Mailing Address mpn 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or 20a. Method of Disposition crematory or other place) Important: If it injury or other 1 X Burial 2 Cremation 3 Removal from State Department Other Specify: Donation 5 22. Name and Address of Facility
Joseph L. Rus Signature of Funeral Service Licenses Approximate Interval t Y. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** lure. List only one cause on each line. Between Onset and M. dical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease 'xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical UNPENDED AMENDED attending physician or use as the burial The law requires that the death certificate be Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. O ⋧ 1 Yes 2 ✔ No 3 Probably 4 Unknown σ. Completed Records, 24b. Were autopsy findings available peen 24a Was an autopsy prior to completion of cause of has performed? death? Νo Yes 2 1 Yes certificate 26.Place of Death (Check only one) 110spital or Attending Physician: 24 hours after death. 25. Was case referred to medical of Vital æ examiner? Other: Nursing Home 5 Residence 6 Other 2 PER/Outpatient 3 Inpatient this 1 ✓ Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day,Year) FOUND: 28c. Injury at Work? 28b. Time of Injury After Manner of Death Certification: Subject shot FOUND: Natural Yes 2 V No Division Pending Funeral Director: stely filled in by the 2214 hrs Mar 14, 2009 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) 1900 N. Pulaski Street, Baltimore, MD determined (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ca (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie March 15, 2009 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD 31. Date filed (Month, Day, Year

Registrar DHMH 17 Rev 1/2001

OCME 2006

State

MAR 1 8 2009

4b. City, Town, or Location of Death

Randalls to WN

If Under 1 Year If Under 24 Hrs.

4c. County of Death

Baltimore

9. Birthplace (State or Foreign

American Indian, Black, White, etc.

Specify: Black

Month

Court Rd Randallstown MD

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 No

Physician /Medical **Examiner**

Funeral

4a. Facility Name (If not institution, give street and number)

Hosp. tol

6. Sex

Center

7. Age (In yrs. last birthday)

thwest

8. Date of Birth 1□M 2XF 8 Months Days Hours Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10b. County iral", or Items 23a or 28a-f show Examiner must be notified at Funeral Director Comico 10e. Street and Number 10g. Citizen of What Country? Apt. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ickerson ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If It any Injury or conce. 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State 16/2004 21. Signato 22. Name and Address of Facility b. Russ Home, P. A. Funeral Ave. Ba 23a. Par 1 Enter the disease, or complications that of seed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shircl, or heart filliure. List only one cause on each line. Immediate Cause (Final Physician Cardispo monory disease or condition resulting in death) /Medical Due to (or as a onsequence of): Examiner Br Advanced Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA P 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director;
completely filled in by the f 2 Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 0065415 march 5,2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MD

State Registrar

010

5401

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ENSON Month 0950 **Physician** OHN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Pasadena Anne Arundel 7858 Mayford Avenue If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Year) **Funeral** Days Min 1944 Maryland 216-42-1346 June 4, Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, The Myster Expulsion must be notified an once. 1 ☐ Yes 2√☐ No Director Anne Arundel Pasadena MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21122 7858 Mayford Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 No If Yes, Give Year or Dates: 162-71 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: white Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) meat cutter food industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Howard Benson Jr Amelia Alberta Klebe ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7858 Mayford Avenue Pasadena, Linda Benson/spouse MD20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 4 Donation

Sign: ture of Funeral S. ruce Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director mon Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final 000 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) s been signed by the s 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b rector, page 2 sh autopsy performed 2 No 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending ours after death. neral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

within 24 hours a

To the Funeral C

completely filled

(Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title aus

Name and address of person who completed cause of death (Item 23a) (Type, Print) W

State Registrar 31. Date filed (Month, Day, Year ♠egistrar's Signature

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month Dey **Physician** March 15, 2:30 p.m 2009 Carol George Bender /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner Carroll 303 Coldstream Close Westminster If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** Months Days Hours XXM 2□ F Yrs. 90 29, 1918 New Jersey Director 152-03-6589 Usuel Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Locetion 10d. fnside City Limits 10b. County 1 ☐ Yes XX No Directo Maryland Carroll Westminster 10g. Citizen of What Country? United States 10f. Zip Code 10e. Street end Number 21158 303 Coldstream Close of America Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Detes: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stetus Black, White, etc. 1 Never Merried 2 Married 1 Yes XX No Specify: altimore, Maryland 21215-0036 Specify: White à 3\ Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementary/Secondary (0-12) 12th Self Employed Tool and Die Maker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be Carol George Bender Marie M. Schmitt 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Linda B. Jewell (Daughter) 303 Coldstream Close, Westminster, Maryland 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) Mar. 17, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2/Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Catonsville, Maryland 2009 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 21. Jonature of Funeral rvio Licensee MMau 3296 Charmil Drive, Manchester, Maryland 21102 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, , or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) i imin r Due to (or es e consequence of): physicien ends the burial-transit The lew requires that the death certificate be axed ted Exami Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): attending ph Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? sate has been signed by the a page 2 should be detached 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed slipidemia 1 ☐ Yes 2 No 1 Yes 2 No is certificate h or Attending Physician: efter deeth. 25. Wes cese referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 2₩No P 1 Yes 5 Residence 6 □Other (Specify) this After this funaral of 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 27. Menner of Deeth 28c. Injury at Work? Certification: 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours efter deeth. To the Funeral Director: Af 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 **Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and manner es steted. 2 **Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner steted. 29a. Certifier Medicai

State

DHMH 16 Rev 6/95

Registrar

(Check

nili 31. Dete filed (Month, Day, Year)

2009

29b. Signature

of deeth (Item 23e) (Type, Print)

ORIGINAL

29c. License number

125 Airport Drive Ste 34 Westminster

29d. Date signed (Month, Dey, Year)

03-16-200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 5 m 2009 Month Physician 520 A M Baker Patricia Ann March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Dundalk 4 Vista Mobile Drive If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🕅 F 220-36-3375 Pennsylvania **Director** August 16,1941 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ira Modical Examiner must be rediffed at once. Director Baltimore 1 ☐ Yes 2 ☐XNo Maryland Dundalk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4 Vista Mobile Drive 21222 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🛣 No Specify. Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 years College (1-4or 5+) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Reilly Doris Rovinus Farnwalt ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Vista Mobile Drive, Dundalk, Maryland Duane Baker Sr. Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 18, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Louden Park 2009 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Disnot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List dely one cause on each line. 7110 Sollers Point Road, Dundalk, Md. 21222 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Terminal /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed sician and burial-frant Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🙀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smithto sule 203 166016 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** 6:30 p Mar 12, 2009 Ci /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** 3106 Cedarhurst Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 1 □ M 2 □ F Jun 2, 1936 Maryland 218-30-7257 Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director **Baltimore** N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3106 Cedarhurst Road 21214 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 ☑ Married þ 1 ☐ Yes 2 ☑ No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Church Musician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stella L. Johnson Harry Conley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3106 Cedarhurst Road Baltimore, Maryland 21214 Kevin Lewis 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/19/09 Pikesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 21. Signature of Funeral/Service Lice 22. Name and Address of Facility Estep Brothers Funeral Service, P 1300 Eutaw Place Baltimore, Md 21 23a. Part I. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 menths? Month Day Year 5 ☐ Other (specify) 4⊡Pregnant at time of death 9□Unknown 9 ☐ Unknowń Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1∐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 NO 1 Tyes 4 ☐ Nursing Home 6 ☐Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA 8c. Injury : Work? Certification:

executed burial-trans and Box 68760 iding physician certificate be the use as atten or P.O. detached signed by t Division or Vital Records, peen page 2 s has certificate spital or Attending Physions after death.

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Funeral

Director

show

Items 23a or 28a-f showner must be notified at

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f Health and Mental item 27 is marked o

permit. Pages 1
Department of He
Important: If iten
any Injury or oth

Physician

/Medical

Examiner

the Medical

72 hours after death with the Maryfand

Baltimore, Maryland 21215-0036

27. Manner of Death	
Natural	5 Pending
2 Accident	investigat
3 ☐ Suicide	6 ☐ Could not

28a. Date of Injury (Month, Day Year)	28b. Time of Injury		2
		М	

	· — recoming r	1011110	1.10010	101100	OHOUNCE
Injury at Work?		28d Des	scribe t	now inju	ry occurred
1 Yes	2 🗌 No				

3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
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28f. Location (Street and Number or Rural Route Number City or Town, State)

diam'r	ou. u	CILITIC	71
		Check one)	only

Medical

29

1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

b.	Signa	ature and title of certifier	
		Dures	l

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

State Registrar

MAR 18 2009



To the Hospital within 24 hours a To the Funeral

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, 08433 For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** John M. Cartrette 2009 9:34 P. M March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Burnie Anne Arundel Baltimore Washington Medical Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Year) Days 1 X M 2 🗆 F 046 40 7001 60 04/16/1948 Maryland Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be published 1 ☐ Yes 2 No Director Glen Burnie Anne Arundel Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21060 U.S.A. 115 Bonnie View Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. Armed 10.0. 1 ves 2 If Yes, Give 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Completed by Year or Dates: Viet Nam 3 Widowed 4 X Divorced White Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) H & S Bakery Foreman 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be file frnent of Health and Mental H tant: If Item 27 is marked oth jury or other traumatic event Be Esmer Cartarette Mary Estelle White ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3803 - 9th Street Baltimore, Maryland 21225 Cathy Smitley aftimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 03/13/2009 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Gonce Funeral Service, P.A. Baltimore, Maryland 21225 4001 Ritchie Highway Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death Last Examiner Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician and for use as the burial-trar resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. the detached g Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 ☐Yes 2 ZNo 1 ☐Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) manner stated within 2 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number 30. Name and eted cause of death (Item 23a) (Type, Print) address of person 31. Date filed (Month, Day, Year) State 8 2009 Registrar

DHMH 17 Rev 1/2001

/Medical Examiner **Funeral** Director death with the Maryland 28a-f show

Physician

1. Decedent's Name (First, Middle, Last)

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be mutified at 72 hours after and 2 should be filed within 1 lealth and Mental Hygiene. m 27 is marked other than " Department of Health Important: If item 27 any injury or other tra Pages 1

Baltimore,

Physician /Medical Examiner

and

The law requires that the death certificate be executed burial-tran attending physician use as the ō signed by the a d be detached for by has been page 2 s certificate or Attending Physician: director. After this filled in by the funeral after death.

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Records,

Division of Vital WILMETTA

To the Hospital within 24 hours a

COATES

Month 03-14-2009 12:45p Wilmetta Augustine West Coates 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Timonium Stella Maris Birthplace (State or Foreign Country)
 KY 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Days Min 1 □ M 2 😾 F Months Hours 72 402-50-7442 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 □ No Director Baltimore N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21216 1111 N. Ellamont Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: Specify: African American Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) USPS Mail Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marguerite English Wilmer A. West ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1655 Kirkwood Rd Baltimore, MD 21207 Anita Thornton/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 Removal from State 1 03-21-2009 Baltin 22. Name and Address of Facility Wylie Funeral Home 4 ☐ Donation 5 ☐ Other (Specify) Baltimore. MD 21. Signature of Funeral Service Licensee 638 N. Gilmor Street Baltimore, MD 21217 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or o' implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. LUNG CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 mon Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 ☐Yes 2X No 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \mathbf{X}$ Other (Specify) **HOSPICE** 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one Nurse Practitioner ner stated. Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number) dorothea, Canolland 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 SR. DOROTHEA MAHOLLAND, CRNP State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 2009

2. Date of Death

DHMH 17 Rev 1/2001

Registrar

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 16 Day 2009 **Physician** 4:55 a M 3 John Drayton /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Balto Genesis Longgreen Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Min 1 X M 2 □ F 24 1927 S.C. Director 251-36-2031 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10b. County 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Michal Examinar must be notified at XXYes 2□No Director MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1404 Edison Highway 21213 SA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 72 hours after 1 Never Married 2 Married 1 Tyes 2 The Yes, Give Year or Dates: 2 No 1 □Yes 2 No Specify: altimore, Maryland 21215-0036 Specify. <u></u> 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r College (1-4or 5+) Continenal Can Co. Elementary/Secondary (0-12) Heavy Machine Operator 9th grade N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Preston Drayton Rosa Mitchell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traur Brenda Durrett-Daughter 3418 S. Aries Court Santa Ana, CA 92704 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Garrison Forest 3-23-2009 Owings Mills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, Md 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final GASTRO INTESTINAL **Physician** HEMORRHA MINUTES ACUTE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of burial-transi signed by the attending physician and be detached for use as the burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 100 2 🗆 No 1 ☐ Yes r Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 4 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deal To the Funeral Director 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 031136

5x

State Registrar 31. Date filed (Month, Day, Year) 32 NAR 1 8 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALLACE, MD 9005 KILBRIDE RD, BATIMORE, MD 21236

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #19a State APM and and Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 0 0

			For amend #19 1 - State Registrar	a State of	r iviai yiai	_	tificate of			енан пу	Reg. No.	2009	08436	
			1. Decedent's Name (First, Middle, La	ast)						2. Date of De Month		Vear	3. Time of Death	
	Physici /Medi		James Ray Duerli	ng						March	n 11, 2009 4:55 AM M			
	Examir		4a. Facility Name (If not institution, gi	ve street and nur	mber)		4b. City, Town, o		of Death			County of Death		
e.F			Oakcrest Villag				Baltin					Baltimon		
- 1	Funeral Director		5. Social Security Number 220-03-3049	Sex 1M∏ M 2□F	7. Age <i>(In yr</i> s. 91	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bir (Month, Da Apr 7,	th ay, Year) 1917	9. Birthr Cour Mary	place (State or Foreign arry) land	
	pu ,		Usual Residence of Decedent		40.00									
	hours after death with the Maryland tural", or items 23a or 28a-f show all Exartinet intel be notified at	Ď	MD 10b. County Baltimo	re		y, Town or Loc altimo:						1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	r 28a	irec	10e. Street and Number				10f. Zip Code				10g. Citize	en of What Cour	ntry?	
	3a o	<u>_</u>	8800 Walther Blv	d			212	234			USA			
١.	death	Funeral Director	11. Marital Status	12. Was Dece	dent Ever in U.	S. 13. V	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1					4. Race - Americ	an Indian,	
Z 9	after or ite	匠	1 ☐ Never Married 2 X Married	Armed For 1 X Yes If Yes, Giv	2 No								_	
AM 0036	ours iral";	d b	3 ☐ Widowed 4 ☐ Divorced	Year or Da	ates: 142-4	6	Lites ZAINO	Ореслу.				Specify: Wh	ite	
~ <u>r</u>	72 h "natu	ete	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Deced	lent's Usual Occu kind of work done OO NOT use retire	pation <i>during mos</i>	t of workin	g	16b. Kind	d of Business/In	dustry	
f:55 AM 21215-0036	within sne.	Completed by	Elementary/Secondary (0-12)	College (1	-4or 5+)						,		-	
7 p	Hygid Hygid ther int, II	ပ္သ	17, Father's Name (First, Middle, Las.	t)		ac	<u>counting</u>	1	er's Name	(First, Middle		inancia	<u>.L</u>	
an	d be a	Be C												
	shoul mark mark	ဥ											Code)	
03/ll/09 5 Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after de Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, it e Medical Eventines once.		19a. promaris Name/Relationship	son			Williams					21015	,	
// c	ss 1 a of He item rothe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date										wn, State	
2/ m	Page nent o		1 ☐ Burial 2 ☐ Cremation 3 L 4 🖾 Donation 5 ☐ Other (Speci		State	,,	and you can be							
alti	partn ports y Inju		21. Signature tuneral S. Wade Pirector State Anatomy Board 655 W. Baltimore Street											
<u> </u>	89 2 2 8 9		tomas	1100	-	Ba	ltimore.	MD_	21201	W CCO	Dal	timore s	creet	
			23a. Part L. Enter the disease, or conshock, or heart failure. List only	plications that ca	aused the deat	n. Do not ente	er the mode of dy	ing, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between	
	Physician		disease or condition	EL	10 S	TAGE	DE	MEN	TIA	-			Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):								
	Cxammer		Sequentially list conditions,	b										
	ted	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events subling indextby lead.	Due to (or as a conseq	serios otjo								
	be executed ician and burial-transit	Xan	that initiated events c											
68760,	icate be executed physician and the burial-transit	E E		,	,									
/	rtificate I ng physi as the b	edical		a										
	n cert	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out							23	3d. Date of delive	эгу	
RA. Box	death cer e attendin d for use	icia	in the past 12 months? 1 □Yes 2 □ No	4 🗌 Pregr	oirth 2□Feta nant at time of c		Ectopic pregnan Other <i>(specify)</i> _	су				Month	Day Year	
P.0.	t the by th	hys	9 Unknown	9 🗆 Unkno	own									
) 's	requires that the leen signed by th nould be detache	by P	Part II. Other significant conditions	contributing to de	eath but not res	ulting in the un	derlying cause gi	ven in Part I		23e. Did t	obacco us	e contribute to th	ne cause of death?	
~ p.c	en si	ed								1 🗆 '	Yes 2	No 3□ Prob	ably 4 Unknown	
$LING_j$ Vital Record	law re as be 2 sho	Completed								24a. Was		24b. Were auto	psy findings available mpletion of cause of	
2 =	The ate h page	ĕ								perfo	rmed? 2 No	death?	2 XNo	
7 ita	iclan: The law certificate has ector, page 2 s	Be (25. Was case referred to medical examiner?					26. Place	e of Death	(Check only o				
of V	Physiclan: this certific ral director.		1 Yes 2 No		npatient 2 🗌		t 3 🗆 DOA		ursing Hom	ne 5□Resi	dence 6	☐Other (Specif	y)	
HO U	After I	Certification: To	27. Manner of Death 1 Natural 5 □ Pending		of Injury th, Day, Year)	28b. Time of Injury	28c. Inju Wo			8d. Describe	how injury	occurred		
Sis	Attending It death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be		ad Indiana Adda]Yes 2		04 4				
∆UE Division	or A after Direc	ertif	Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									r Houte Number,		
	Hospital 24 hours a Funeral I												tated.	
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only 2 Medical Exa	miner: On the ba	asis of examina ner stated.	tion and/or inv	estigation, in my	opinion, de	ath occurre	ed at the time,	date and p	place, and due to	the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of certifier	0.		0	29c. Licen		< n ^		29d. Date	signed (Month,	Day, Year)	
			1 quotive	Theis	CRNI		RI	7435	180		3	111/09		
			30. Name and address of person who	completed cause	e of death (Iten	n 23a) (Type, F	Print\				^		/	
			Justine Preis	2832	(A)A1	THER	BLUI)	DAL	210.1	MJI	21234	ī.	

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month Pay Year) NAR 1 8 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Helen Delisle 4:10 A. M March 16, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore Futurecare Irvington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days 1 ☐ M 2 🔀 F 89 Director 218 05 3732 Maryland 07/15/1919 Usual Residence of Decedent 10c. City. Town or Location r 28a-f show notified at 10h County 10d. Inside City Limits 1 ☐ Yes 2 X No Anne Arundel Pasadena Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural" or items 23a or other traumatic event, the Medical Examiner must be 7945 Elizabeth Road 21122 U.S.A. death Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 👿 No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 X No ģ Specify. 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be to nent of Health and Mental 1 int: If item 27 is marked of Jan Dworkowski Josephine Oczus 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Delisle / Son 205 W. Greenwood Road Linthicum, Maryland 21090 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Injury or important: I any Injury o Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) MD. State Veteran Cem. 03/23/2009 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. Baltimore, Maryland 21225 Ritchie Highway or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one gluse on each line. 23a. Part1. Enter the disease shock, or heart failure. Approximate Interval Betw Immediate Cause (Final CEREBRO VASCUL THEROSCHEROTTO Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed burial-transi Exami and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician for use as the buris Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ned by the atter 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 4 □Unknown 2 No 3 Probably 1 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 12 ☐ No 24a. Was an Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: P 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Mayour of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident after death filled in by the 3 Suicide 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

DHMH 17 Rev 1/2001

MAR 18 2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835 Registrar's Signature

29b. Signature and title of certifier

29c. License number

Suit 23

29d. Date signed (Month, Day, Year)

BALD MN 31209

09-02060 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Christopher Esson 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 0310 hrs Christopher Jerone Esson March 13, 2009 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death I-495 Inner Loop Capitol Heights Prince George's If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 6 Sex oreign Days Hours Director 06-28-1977 1X M 2 F Country) 667-36-8753 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Yes 2 X No 28a-f show GA Rockdale with the Maryland Conyers Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? notified at 1329 River Club Drive 30012 Jamaican Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Never Married 2 X Married Yes 2 X No ō Give Yea Yes 2 X No specify: Specify: African American Widowed Divorced à 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 the Medical marked other than Baltimore, MD 21215-0036 12th Truck Driver Trucking Company nt of Health and Mental Hygiene.
it: If item 27 is marked other th
other traumatic event, the Med 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Heron Esson Sonia Guy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joel Esson 1329 River Club Drive Conyers, GA 30012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Spanish Town, Jamaica 1 X Burial 2 Cremation 3 Removal from State 03-25-2009 **28** Dove Cott rtant: Donation 5 Other Specify: Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P. A. 638 N. Gilmor Street Baltimore, MD 21217 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a, Part I. Enter the disease, or **Physician** failure. List only one cause of Between Onset and /Medical Death a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, The law requires that the death certificate be executed Physician/Medical X AMENDED #20b, per FH g889 3/19/09 TT UNPENDED attending physician for use as the burial Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. ģ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 🗸 Yes No 25. Was case referred to medical 26.Place of Death (Check only one) the Hospital or Attending Physician: Division of Vital Be Hospital: Other: Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene ٩ 1 Yes 28a. Date of Injury After 27 Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Mar 13, 2009 Pedestrian struck by vehicle 1 0255 hrs Natural Yes 2 V No Director: ed in by the f Pending hours after death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) I-495 Inner Loop, Capitol Heights, MD determined (Specify) Interstate Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 13, 2009 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. 31. Date filed (Month, Day, Year) MAR 18 2009 32. Registrar's Signature State

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State

31. Date filed (Month, Day, Year)

MAR 18 2009

32/ Registrar's Signature

		_ For	Please	Type or Prin					_		•	
		1 - State Registrar				Cert	tificate of	Death		Reg. No	.2009) 08446
		1. Decedent's Nam	ne (First, Middle, L	ast)					2. Date of D	eath		3. Time of Death
Physicia /Medic		Margare	et Fuchs						Febru	ary 2	23, 2009	6:59 PM M
Examin				ive street and number)			4b. City, Town, c	or Location of Deat	h		County of Dear	
		Gilchri	st Hospi	ce			Towson	l		F	Baltimon	re e
Funeral		5. Social Security			e (In yrs. last b		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of B	irth	9. Bir	thplace (State or Foreign ountry)
Director		217-38-9	1548	1□M 2√F	71	Yrs.	Month Buye	Tiouro Mini.	Apr 9,			ryĺand
pu s		Usual Residence of 10a, State	f Decedent 10b. County		10c, City, To	wn or Loca	ation					10d. Inside City Limits
laryla sho	ō				roor only, ro							1 □ Yes 2 □ No
the N	Director	MD 10e, Street and Nu	Balti	Lmore		ватс	imore			10a Cit	tizen of What Co	
with a	₫		Skys Cou	rt #101			i i	21209		Tog. Oil	USA	outra y r
eath	Funeral		DRYS COL	12. Was Decedent	Ever in IIS	13 W			Specify Vels or N	0.	14. Race - Ame	rican Indian
ter d	딢	11. Marital Status	ried 2 Married	Armed Forces?		if	Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	to Rican, etc.)		Black, White	
irs af	þ	3 ☐ Widowed	_	If Yes, Give Year or Dates:		11	□Yes 2XTNo	Specify:			Specify: W	hite
filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ent, the Modical Examination rest to redified at	Completed		15. Decedent's E	Education	16	a. Decede	ent's Usual Occup	pation		16b. K	ind of Business/	Industry
hin 7; 9. 3n "n	ple	(Spe	ondary (0-12)	rade completed) College (1-4or 5	<u></u>	life. D	ind of work done O NOT use retire	during most of word)	rking			
d with	Ö	12	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2	,	sc	cial wo	rker			clinic	a1
e file al Hy foth	Be (17. Father's Name						18. Mother's Nar	ne (First, Middle	e, Maiden	Surname)	
uld b Ment arkec	2	Claren	ce Raymon	nd Zarfoss				Marga	et Elle	en La	uer	
2 should be and Mental is marked craumatic ev			lame/Relationship		19	_		and Number or R			or Town, State, 2	Zip Code)
and and not		Gilchri	st Hospid	ce		555	Towsont	own Blvd	Towson,	MD	21204	
of H of H fiter		20a. Method of Dis		☐ Removal from State	20b. Place ceme	of Disposi tery, crema	ition (Name of atory or other pla	ce)	Date	20c. Lo	ocation - City or	Town, State
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinations to other traumatic event, the Modical Examinations to other traumatic event.		21. Signature of E	uneral Service Lice	wade Dir	ector	St.	Name and Addre	ess of Facility Omy Boar	d 655 W	. Bal	ltimore	Street
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Physician	5). (5	Immediate Cause disease or condition	on	PANO	creati	L.C	cano	~				Onset and Death
/Medical Examiner		resulting in death)		Due to (or as	a consequenc	e of):						
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nn: T tifficat or, pa		25. Was case refe	rred to medical	1				OC Disease of Day	1 Tes		1 ☐ Yes	2 □ No
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nding th. :: Afte	atio	1 Natural 2 ☐ Accident	5 Pending investigation	(Month, Da	ly, Year)	Injury		rk?]Yes 2 □No				
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al or s afte	Certification: To	4 🖸 Homicide		building, et	c." (Specify)				City or ro	wn, State	2)	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the buri		29a. Certifier (Check only	Certifying F	Physician: To the best	of my knowled	lge, death	occurred at the t	ime, date and plac	e, and due to th	e cause(s) and manner a	s stated.
he H in 24 he Fr	Medical	one)	, ∠	aminer: On the basis of and manner st	ated.	and/or inve	esugation, in my	opinion, death occi	urred at the time	, date and	a piace, and due	to the cause(s)
Vith To t	Σ	29b. Signature and	title of certifier	4			29c. Licens	se number	_		te signed (Mont	
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Registr	ar	MA	R 18200	y senon	P. 1	gar						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08441 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 8, George H. Gernand 1:15 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Towson 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb 22, 1926 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F 83 216-22-8801 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10h. County 10d Inside City Limits Department of Health and Mental Hygiene, important; or items 23a or 28a-f show important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Martial Examinatment be retified an once. MD Director Baltimore Timonium 1 ☐ Yes 2 ▼ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Kilglass Court #104 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2X No Specify: If Yes, Give Year or Dates: 44-46 Specify: white <u>Ş</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Leslie Gernand ည Beulah Romaine Erb 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2 Kilglass Court #104 Timonium, MD Rita Gernand/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Euroral Service Licensee Director State Anatomy Board 655 W. B

Raltimore, MD 21201

23a. Part 1 Enter the dise see, or complications that caused the death. Shock or heart failure. List only one cause on each line. 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** To state disease or condition resulting in death) /Medical Due to (as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Feta! death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy
performed2

1 Yes 2 No 2 □No 1 ☐ Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

P.O. Box 68760, Division of Vital Records, attending physician and for use as the burial-trar

signed by the a d be detached f

icate has been signated by page 2 should b

certificate

show

with 1

death

should be filed within ind Mental Hygiene.

Pages

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certificat completely filled in by the funeral director, p

State Registrar

Medical

4 Homicide

(Check only one)

29a, Certifier

29c. License number
29d. Date signed (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A Riley Charles St. Balks Md 2020

31. Date filed (Month, Day, Year)

32 Paistrad's Signed. 31. Date filed (Month, Day, Year)

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No.2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician Jilliam /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner anc8. Date of Birth 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Funeral 1**反** M 2□ F Months Days Hours Min. 215 28 3883 Director Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, It is Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Garrett Swanton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21561 4190 Dry Run Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 2 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Lever Brothers 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William E. Gedden Sr. Leona F Durst ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice A. Menear 4190 Dry Run Road, Swanton, Maryland Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 19. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Halethorpe, MD. Meadowridge Cemetery 2009 4 ☐ Donation 5 ☐ Other (Specify) gn ture of Fureral Service License Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a, Part 1. Enter the disease, of shock, or heart failure. Lis complications that caused the deated Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician aspiration DININITES /Medical (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 2 No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Wital Records, þ The law requires 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ▼No 24a. Was an autopsy 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ivision of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending investigation 1 Tyes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 1x CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Limit Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signay e and title of certifier 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address

DHMH 17 Rev 1/2001

Registrar

marg

Physician

/Medical

Examiner

Funeral

Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

	e Type or Print in Bl State of Maryland				_	08443
For State Registrar	,	Certificate		, 0	g. No. 2003	00445
I. Decedent's Name (First, Middle, L Jennie	.ast)	Gr	aves	2. Date of Death Month	Day Year	
a. Facility Name (If not institution, g	ive street and number)	4b. City, 7	Town, or Location of Dea	th	4c. County of Dea	ath
· · · · · · · · · · · · · · · · · · ·	Medical Cent Sex 7. Age (In yrs. Ia		OWS	8 Date of Birth	9 Bi	timore rthplace (State or Foreign
166-12-7030	1□M 2 X F 95	Yrs. Months	Days Hours Min		Year) C	MD
Usual Residence of Decedent Oa. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
MD Balti	more P	arkville				1 ∐Yes 2¥∑No
0e. Street and Number	Dood Ant C	10f. Zip	21234	10	g. Citizen of What C	•
1805 Aberdeen	12. Was Decedent Ever in U.S	13. Was Deced	ent of Hispanic Origin? (ify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Am	erican Indian,
1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 3 ☐ No If Yes, Give	If Yes, spec 1 □ Yes 2		rto Rican, etc.)	Black, Whi	ite, etc. Black
3 Widowed 4 □ Divorced 15. Decedent's	Year or Dates:	16a. Decedent's Usua	••	1	6b. Kind of Business	
(Specify only highest g	College (1-4or 5+)	(Give kind of won life. DO NOT us	k done during most of wo e retired)	orking H	leryton :	•
12th grade	2yrs	Nurs		me (First, Middle, M	lospital	
7. Father's Name (First, Middle, La: Jerimiah Buch				obinson	alderi Sumame)	
9a. Informant's Name/Relationship	(Type. Print)		(Street and Number or F			
William Hall-	4	_	onwing Pl			
0a. Method of Disposition 1 □ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	Hemoval from State	ce of Disposition (Nammetery, crematory or of Memoria	herplace) 1 Park 3/		oc. Location - City o	
1. Signature of Funeral Service Lic		22. Name and	Address of Facility F/H West			
23a Part 1 Enter the disease or co	mplications that caused the death.		abash Ave			21215 Approximate
shock, or heart failure. List on mmediate Cause (Final disease or condition	ly one cause on each line.					Interval Between Onset and Death
resulting in death)	a. ACUTE MYOC Due to (or as a consequence)		IFBRC11UN			3_DAYS
Sequentially list conditions, any, leading to immediate ause. Enter Underlying	b. SEVERE TRI Due to (or as a conseque					
rause. Enter Underlying Cause (Disease or injury hat initiated events	Ž.	ARTERY_I	TSEASE			
esulting in death) Last	Due to (or as a conseque	ence of):				
	CHRONIC OB	STRUCTIVE	PULMONAR	Y DISEAS	6E.	
F FEMALE: :3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 Ectopic pr			23d. Date of do	elivery Day Year
9 ☐ Unknowh		ting in the underlying ca	ause given in Part I.	23e. Did tob	acco use contribute	to the cause of death?
				1 □ Yes	s 2 No 3 7	Probably 4 🗍 Unknown
				24a. Was an autopsy perform 1 □ Yes 2	prior to	
25. Was case referred to medical examiner?	Hospital:			eath (Check only one		
1 Yes 2 No 7. Manner of Death 1 Natural 5 Pending	1 Inpatient 2 E		A Other: 4 Nursing 8c. Injury at Work?	Home 5 Resider 28d. Describe how		ecify)
Accident investigat Accident investigat Graph Graph Graph	be 290 Place of Injury. At hor	M M ne, farm, street, factory,	1 Yes 2 No	28f. Location (Str. City or Town,	eet and Number or F State)	Rural Route Number,
	Physician: To the best of my know aminer: On the basis of examinati	rledge, death occurred	at the time, date and pla			
one) 29b. Signature of title of certifier	and manner stated.		License number		d. Date signed (Mo	
1 amo	Constant!	101/b		25	2/17/1	59
O Name and address of person wh	no completed cause of death (Item)31476 >	ر	1. 10	
		7601 OSLE		are a same of a same same as a	. proc. garac. c. p. g. proc. b. c. sparec.	ans. a me. me. b

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] 9 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 4:53PM Month 03 Day **Physician** JOSEPH H. GREVE, SR. 6 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City Town, or Location of Death Examiner Franklin Square Hospital Center Rosedale Baltimore Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Social Security Number **Funeral** Year) Months Days Hours Min. tXXM 2□ F 79 076-22-7000 New York Director July 9,1929 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County ral", or items 23a or 28a-f show 1 ☐Yes 2X No Director Baltimore County Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 USA 9 Cedarberg Ct. Apt. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 10/CX/es 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married (5/CVC)/OSCP DBaltimore, Maryland 21215-0036 WW 11 'natural", or White 1 ☐ Yes 2 T¥No Specify ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) N/A Elementary/Secondary (0-12) Truck Driver 8 yrs. Gasoline Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Greve Mary Ranken ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patricia L. Greve (Wife) 9 Cedarberg Ct. Apt. B. Baltimore, Md. 21234 Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State NBurial 2 ☐ Cremation 3 ☐ Removal from State 3-19-2009 Parkwood Cemetery 4 Donation 5 Dother (Specify) Baltimore, Md. 2. Name and Address of Facility Lassahn Funeral 7401 Belair Rd. 21. Signature of Funeral Service Licensee Home Baltimore, Md. 21236 23a. Part 1. Enter the disse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CHE Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Endocarditis the Hospital or Attending Physician: The law requires that the death certificate be executed Valve Mitra anding physician and use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I à 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s autopsy performe ormed? 2 No 2 No 1 □ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28a. Date of Injury (Month, Day, Year) 28h Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 MC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie, D0063974 30. Name and address of person who ophpleted cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive, Baltimore, MD 21237 Siddigi IMran

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

Jose

32. Pegistrar's Signature

09-02005 Johnathan Hazel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Ce	ertificate of	Death		Reg. N	lo.	
Phyșiciar ical Examin	1/	1. Decedent's Name (First, Middle,Last	hnathan	Hazel			2. Date of Death Month Day March 10, 200	v Year	3. Time of Death 2103 hrs
	8	4a. Facility Name (if not institution, give			1b. City, Town, or	Location of Death		4c. County of Dea	
		University Hospital			Baltimore	Turis i anis	- lo p		
Funeral Director		5. Social Security Number 6. Se 218-81-1411 1 X	7. Age (In yrs.	Yrs.	If Under 1 Yea Months Days			Fore	ign
	ŀ	Usual Residence of Decedent	1	115.	19 1		3 2 4 2		ountry) MD
* any	ſ	10a. State 10b. County	10c. City	y, Town or Locati	on				10d. Inside City Limits
Maryland 28a-f show 1 at once.	<u></u>	MD	N/A E	Baltimo					1 Yes 2 No
e Mary or 28a ied at	ଥା	10e. Street and Number	t Court		10f. Zip Code 2121	7	_	Citizen of What Co	untry?
3, IVID 21219-1030 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiest tem 27 is marked other than "natural", or items 23a or 28a-fish traumatic event, the Medical Examiner must be notified at once	<u> </u>	1605 Spray Cour	12. Was Decedent Ever in U	J.S. 13. Wa	s Decedent of His				erican Indian, Black,
r item	Funeral	1 X Never Married 2 Married	Armed Forces? 1 Yes 2 No		es, specify Cubar			White, etc.	
ral", o	ᆰ		If Yes, Give Yeer or Dates:		Yes 2 X No			Specify: B1	
hours "natu		15. Decedent's Education (Specify on Elementary/Secondary (0-12)	College (1-4 or 5+)		t's Usual Occupat ost of working life			. Kind of Business	s/Industry N/A
Hygiene. I other than the Medical	Completed	N/A	N/A						
led wil Hygier other the M	ᇹ	17. Father's Name (First, Middle, Last)				18.Mother's Name	e (First, Middle, Maide	en Surname)	
Mental] marked c event,	~	Victor Hazel				Alicia	Brown		_
s I and 2 should be filed within of Health and Mental Hygiene. If item 27 is marked other the her traumatic event, the Med	- 1	19a. Informant's Name/Relationship (T					Rural Route Number,		
and 2 sho dealth and item 27 is traumat		Alicia Brown-M 20a. Method of Disposition	20b.	L60. Place of Dispos	Spray	Court netery,	Balto, I	MD 2121 c. Location - City of	7 or Town, State
Pages 1 ent of H int: If it	J	1 X XBurial 2 Cremation 3		crematory or oth		w., 2	10 200		WD
permi Pages I ai Department of He Important: If ite injury or other tr	ŀ	4 Donation 5 Other Specify: 21. Signature of Fun Service Licen:		22. N	lame and Address	of Facility Ma	19-2009 1 arch Eas	Lansdow EF/H	n, MD
i Francis	1	Brank Mill					Avenue		Md 21202
hysician /Medical		23a. Part I. Enter the disease, or complete failure. List only one cause on ea		n. Do not enter th	ne mode of dying,	such as cardiac of	or respiratory arrest, s	shock, or heart	Approximate Interva Between Onset and
xaminer	1	Immediate Cause (Final disease a. or condition resulting in death)	Asphxia Due to (or as a consequence	of):					Death
	-	Sequentially list conditions, b.	Suc to (Si as a consequence	51).		Yes.			
	<u> </u>		Due to (or as a consequence	of):					
85. I	Examiner	events resulting in death) Last	Due to (or as a consequence	of):					
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cate be ex physician he burial	Medical	IF FEMALE:	AMENDED 23a,2/	_	ber me 8			201 5-1	
rtificate ling phy as the	2 2	23b. Was decedent pregnant in the past 12 months?	1 Live birth	,	tal death 3	Ectopic pregna		23d. Date of delive Month	Pry Day Year
leath certiff e attending for use as:	Pnysician	1 Yes 2 No 9 Unknown	4 Pregnant at time of d	leath 5 Oth	ner (Specify)				
rres that the de		Part II. Other significant conditions		resulting in the v	nderlying cause g	iven in Part I.	23e. Did tobaco	co use contribute t	o the cause of death?
es tha igned	2						1 Yes 2	✔ No 3 Pro	obably 4 Unknown
- S- 1							24a. Was an		autopsy findings available completion of cause of
v requiring been sighould be	e Le						autopsv		
The law require ate has been si age 2 should b	omplete						autopsy performed	? death?	
ian: The law requir certificate has been si ctor, page 2 should b		25. Was case referred to medical			26.Place	of Death (Check	performed Yes 2	? death?	
ysician: his certifi director,	0 0	examiner? 1 ✓ Yes 2 No		ER/Outpatient	3 DOA	Other Nursi	performed 1 Yes 2 only one) ng Home 5 Resi	? death? No 1 1	Yes 2 No
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Spital or Attending Physician: spital or Attending Physician: hours after death. neral Director: After this certifi filled in by the funeral director,	Certification: 10 Be	examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending Investigation X Accident Investigation Suicide 6 Could not to determine to determine to Could not to the could not to t	28a. Date of Injury - At It (Specify) an: To the best of my knowled	28b. Time of Ir 8:18pt home, farm, stree	3 DOA njury 28c. Injur 1 Net, factory, office become dat the time, da	Other Nursing at Work? Yes 2 No uilding, etc.	performed 1 Yes 2 only one) ng Home 5 Resi 28d. Describe how i face over the side 28f. Location (Stree or Town, State) 1605 Spray due to the cause(s)	dence 6 Oth njury occurred r plastic of the bott and Number or F y Ct Apt. and manner as sta	er: c bags place ed Rural Route Number, City 1 Balto, Mo
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH Physician Margaret Handel 13,2009 5:41FM /Medical 4a. Facilit (Name # not institution cojus street and sumber 1 Center 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. B. Date of Birth (Month, Day, Year) March 11 1954 9. Birthplace (State or Foreign **Funeral** Months Days Min. Hours 1 □ M 2 □ F 213 52 7153 Baltimore, Maryland Director 55 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene, ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show Jry or other traumatic event, the Wedical Exeminer must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No Maryland Baltimore Parkville 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 8413 Kingsridge Road 21234 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∐Yes 2 XXNo If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Program Policy Analyst Social Security Administration 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilfred Handel Margaret C. York 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret C. Handel (Mother) 8103 Old Harford Road Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Pages
Department of Important: If its
any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Immanuel Lutheran Cemetery March 16 2009 Baltimore Maryland 21. Sonature of Funeral Service Licensee 22. Name and Address of Facility
Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPTIC SHOCK **Physician** /Medical Due to (or as a consequence of):
FERFORATED COLON Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of, Examiner The law requires that the death certificate be executed ULCERATIVE COLITIS burial Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the attending p as IF FEMALE: asn If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2 No cate has been si 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Date of Injury
(Month, Day, Year)

28b. Time of Injury
Injury
28c. 1 ☐ Yes Certification: To After thi funeral of 27. Manner of Dat 1 Natural 2 Accident 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation ours after death.
neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a the Hospital 29a, Certifier CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

MAR 18 2009

FRANCIS KHOO M.D.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

D 30263

7601 OSLER DRIVE TOWSON MARYLAND 21204

3-13-

DHMH 17 Rev 1/2001

			For State Registrar	State of M	aryland /		ment of F <i>icate of l</i>	lealth and N <i>Death</i>	Mental Hy	gien) Reg. No	7009	08447		
			Decedent's Name (First, Middle,	Last)					2. Date of D	eath		3. Time of Death		
	Physic /Medi		John Raymo	nd Benson	Hafe	V			March	Da 4		12:16 AM		
	Exami	ner	4a. Facility Name (If not institution,			4b		r Location of Death		40	. County of Deat	h		
			Flavbor Hoss		je (În yrs. last	hirthday) If	Under 1 Year	If Under 24 Hrs.	O Date of Pi	rth	N/A	hplace (State or Foreign		
	Funeral Director		217 34 8678	18 M 2□F	69		onths Days	Hours Min.	8. Date of Bi (Month, D) 9. Bro	ryland		
	aryland show		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Location	on					10d. Inside City Limits		
	a-fsh	ctor	Maryland Anne	Arundel	Ва	1timore	е					1 □Yes 2 ☑ No		
	or 28	Dire	10e. Street and Number			1	0f. Zip Code			10g. Ci	tizen of What Co	untry?		
	ath w	ā	601 Cresswell					1225			U.S.A.			
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evertimes is used by medical and other traumatic event.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1			Decedent of H s, specify Cuba ∕es 2 ∑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)	0-	14. Race - Ame Black, White Specify: W			
21215-0036	2 hou	ted	15. Decedent's (Specify only highest		16	6a. Decedent	s Usual Occup	ation		16b. K	(ind of Business/			
215	hin 7. e.	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5	5+)	life. DO N	IOT use retired	•	ing					
21	filed wit Hygien other th	Con	11th		,	Truck	Drive					Company		
Maryland	should be filed within nd Mental Hygiene. marked other than ' imatic event, the '	To Be	17. Father's Name (First, Middle, L	^{ast)} George Ha	fer				e (First, Middle 1ma E1s	ddle, Maiden Surname) 1sroad				
Aary	2 shou and N is mai	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Rol								Route Number, City or Town, State, Zip Code) altimore, Maryland 21225				
	1 and Healtl em 27		20a. Method of Disposition	/ wile					Date Date		Mary Lar			
mor	Pages nent of unt: If it iry or c		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe				n (Name of ry or other plac : Cemet.	ery 03/1				Maryland		
Baltimore,	permit. Pages 1 and 2.s Department of Health a Important: If item 27 is any Injury or other trau		21. Signature of Funeral Service Li	censee	sh.	22. Na	me and Addres		nce Fur	iera.	l Servic			
			23a. Part 1. Enter the dise	omplications that caused	the death. D						ne, nai	Approximate Interval Between		
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	/Medical		resulting in death)	a	a consequenc							- tay		
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18/	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting doubt), lead	Due to (or as	a consequenc	sa ut):						1 day		
Y	xecut and Il-tran	хап	that initiated events resulting in death) Last	c. HCOK Due to (or as	a consequence	tory to	Elore					1 any		
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89	ertifica ing ph e as th	Med	IF FEMALE:											
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σ.	s that ned b		Part II. Other significant condition	s contributing to death b	ut not resulting	g in the underl	ying cause give	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?		
ords	w requires to be significant should be	ed b	Diabetes	Divertical	osis	Corona	ary auter	mil diseuse	10	Yes 2	□ No 3 □ Pro	obably 4 Honknown		
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ā	ician: Th certificate ector, pag	ပ္ပ	25. Was case referred to medical	discole				00 DI (D (1 □ Yes	2 700		2 □No		
>	nysician: nis certific director,	To Be	examiner?	Hospital:	ent 2 ☐ ER/0	Outnatient 3	□ □ □ Othe	26. Place of Deatl	-		6 ☐Other (Spec	- 14 A		
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io	endin sath. or; Af he fur	atic	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investiga	tion	y, reary	n jary		Yes 2 □No						
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best kaminer: On the basis o	of my knowled	dge, death occ	urred at the tin	ne, date and place,	and due to the	cause(s	s) and manner as	stated.		
4	thin 24	Medical	one) 29b. Signature and title of certifier	and manner sta	ated.		29c, License							
0	5 × 5 0	_	Gabriel Tipes	M.D			RES			290. Da	te signed (Month			
			30. Name and address of person w		eath (Item 23s	a) (Tyne Print				1200	14 2	009		
			Jub nel Tina	0 3001 +	Luover	1 5 tue		Himse MI	2/22	.7.				
	Sta		31. Date filed (Month, Day, Year)	32. Registr			0		7,00	J				
	Registr	ar	MAR 1820	99 Serena	1. 1									

			For - State Registrar	State of Mar	yland / I	Departme <i>Certifica</i>			Mental H	ygiene Reg. No.	ZHII	3 (8448
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give st	reet and number)		4b. Cit	y, Town, or	Location of Dea	2. Date of D Month	eath Day		,90	Time of Death
	Funeral Director	CI	Toward Courty 5. Social Security Number 332-60-8609 1	GENERN	(In yrs. last bill 40	si tel	er 1 Year	If Under 24 Hrs Hours Min	E, A	irth Day, Year) - 196	/fee/ 8 I1	rthplace (Fountry)	State or Foreign
	the Maryland 28a-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD Howard 10e. Street and Number	I	0c. City, Tow	columbi	La Lip Code			10a, Citi	izen of What C	X	side City Limits ☐Yes 2☐No
9003	be filed within 72 hours after death with the Maryland that Hygiene. dother than "natural", or items 23a or 28a-f show event, the Modrel Examinar must be notified at	by Funeral	7064 Gentle Sha 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	de Rd. # 2. Was Decedent Event Armed Forces? 1Yes	er in U.S.	1 □Yes	edent of Hi ecify Cuba 2 XNo		Specify Yes or N to Rican, etc.)	10-	USA 14. Race - Am Black, Whi Specify: B	erican Ind te, etc. lack	
121215-0036	s 1 and 2 should be filed within of Health and Mental Hygiene. item 27 is marked other than "cother traumatic event, the Market of the traumatic event, the Market traumat	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+)		a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) EEG technician			rking me (First, Middli	Chi	Kind of Business/Industry ildren's Hos		
laryland		To Be	Corinth H 19a. Informant's Name/Relationship (Typ		191	Mailing Addre	ss (Street a	Etta	Mae D	eLap	p or Town State	Zip Code)
Baltimore, Maryland			Gloria Hicks/ S 20a. Method of Disposition 1 Durial 2 Cremation 3 Re 4 Donation 5 Other (Specify)		20b. Place o cemete	f Disposition (N ry, crematory or St. Hom	ame of other place e Cel	m. 03-2	Date 21-09	Fore	est Pa	rTown, St rk,	tate
Balti	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service License	Dely) JI		10583	Mic	ss of FacilityRo	t Ln.	Whit		ins,	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the cause on each line. Due to (or as a control of the cause)	5/1	/		g, such as cardia	c or respiratory	arrest,		Appro Inten Onse	oximate val Between et and Death
×	cate be executed oblysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events culting in death) Last	Due to (or as a consequence of): c									
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Division of V	ding Phys h. After this funeral dir	Certification: To B	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	spital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day, Y 28e. Place of Injury	28b.	Time of njury M	28c. Injury Work 1 □	er: 4 🗆 Nursing I	Home 5 ☐ Res 28d. Describe	sidence 6 how injury	y occurred		D. Niversky
á	Hos Fun tely	Medical Certif	29a. Certifier (Check only one) 29 Medical Examino	building, etc.	(Specify) my knowledge xamination ar	e, death occurre	d at the tin	ne, date and plac pinion, death occ	City or To	e cause(s)	and manner a	ıs stated.	
U	the lithin 2 the orther	Mec	29b. Signature and title of certifier	and manner state	u.	2	9c. License	number		29d. Dat	te signed (Mon	th. Dav. Y	(ear)

Division of Vital Records, P.O. Box 68760, To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by the

ise of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death I. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day **Physician** Year 30A M LOUISE JOYNER 2009 MAR 14, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FUTURECARE - ATHOL BALTIMORE If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 😾 F Months Days Hours Min Director <u>217-22-8336</u> 89 6, APR. 1919 SC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Fysical Pages. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1XIYes 2 □ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22 S. ATHOL AVE Funeral USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedon. _ Armed Forces? 1 ☐Yes 2X No 1 Never Married 2 Married Specify: BLACK If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify. <u>≨</u> 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12TH HOMEMAKER HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ SAINT GARDNER MEG OWENS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY POWELL/NIECE 3006 PRESBURY ST., BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5712 O DONNELL ST. 1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify) CARMEL 03/18/2009 BALTIMORE, MD 21224 22. Name and Address of Facility WESLEY CHAVIS, JR., FNRL. HM. <u>2007-09 EASTERN AVE., BALTIMORE, MD</u> 23a. Part 1. Enter the dis shock, or heart fall se, or complications the List only one cause aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart falls **Physician** Ker disease or condition resulting in death) /Medical due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ cate has been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes ♣□₩0 autopsy certificate perfor 2 1 □ Yes director 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner' Other: 4 Hursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. n 24 hours after death.

e Funeral Director: A pletely filled in by the fu 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

P.O. Box 68760, Records. Division of Vital Hospital or Attending Physician:

within 2

State Registrar

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

Q A

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State	d / Department of Health and I Certificate of Death		-2004 08550
	Physic	an	Registrar 1. Decedent's Name (First, Middle, Last)	Octanicate of Death	Reg. I	Oay Year 3. Time of Death
	/Medi	cal	John A. Jones 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	MAR	11 2009 530 PM 4c. County of Death
	Examil	lei	St Agnes hospital	Baltimore		MA
	Funeral Director		5. Social Security Number 6. Sev 7. Age (In yrs. $240-48-7257$ 1 M $2\Box F$ 7. Age (In yrs.	Ast birthday) If Under 1 Year If Under 24 Hrs. Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	land bw		Usual Residence of Decedent 10a. State 10b. County 10c. Cit	y, Town or Location	Sept. Sit	10d. Inside City Limits
	e Mary 8a-f she etified a	ctor	Md. N/A E	Saltimore		1 XYes 2 No
	with the	al Dire	10e. Street and Number 433 M Aisquith St	10f. Zip Code	10g. (Citizen of What Country?
	er deati items 2 ner mus	Funeral Director	11. Marital Status 12. Was Decedent Ever in U Armed Forces?	S. 13. Was Decedent of Hispanic Origin? (Sr If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- po Rican, etc.)	14. Race - American Indian, Black, White, etc.
9036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at		1 Never Married 2 Married 1	1 ☐ Yes 2 ☑ No Specify:		Specify: Black
15-0	iin 72 h n "natu Aedical	Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king 16b.	Kind of Business/Industry
1212	led with lygiene her tha nt, the h	Com	Elementary/Secondary (0-12) College (1-4or 5+)	Trucker		ransportation
rlanc	uld be fi Jental H rked ot tic ever	To Be	17. Father's Name (First, Middle, Last) Sam Jones	18. Mother's Nam	e (First, Middle, Maid	en Surname) (
Maryland 21215-0036	d 2 sho th and ∆ 7 is ma trauma		19a. Informant's Name/Relationship (Type. Print) (Sister)	19b. Mailing Address (Street and Number or Ru	ral Route Number, City	y or Town, State, Zip Code)
ore,	es 1 an of Heal f Item 2 r other		20a. Method of Disposition 1 Disposition 20b. F	Place of Disposition (Name of emetery, crematory or other place)	Date 20c.	Location - City of Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service, Licensee	OSS Creek #5 3/15	12009 Fa	yette, North Carolina
Ba	permi Depar Impor any ir		Joseph L. Russ	22. Name and Address of Facility JOSEPH L. RUSS F 2222 W. North	Ave. Ral	tome, P.A.
	Dhysisian	8 10	23a. Part Lenter the chease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final	n. Do not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
•	Physician /Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence)	uence of):	auinon	na Months
	28 20 20 20 20 20	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	uence oll).		
A	executed n and ial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C	iance of)		
5 8760	ate be executed thysician and the burial-transit	dical E	d			
NES Box 68	certifica nding phase as t	/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregna	ncv		204 8-1-44 1
. B. €	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	in the past 12 months? 1 Yes 2 No	death 3 □Ectopic pregnancy		23d. Date of delivery Month Day Year
P. G.	s that th ned by t detach		9 ☐ Unknown Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
ords	requires een sigi nould be	ted by			1 ☐ Yes	2 No 3 Probably 4 Unknown
H/N Record	The law ate has b	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Viital	Physician: 'this certificaral director, p	Be	25. Was case referred to medical examiner?		1 Yes 2 2 1 h (Check only one)	lo 1 □Yes 2 □ No
ō	ig Phys ter this neral dir	n: To	27. Mann, of Death 28a. Date of Injury	001 77	me 5 Residence 28d. Describe how inj	
Division	Attending r death. ector: After by the fune	Certification:	2 Accident investigation	M 1 ☐ Yes 2 ☐ No	206 Landing (Otto to	- (N. 1
Div	ital or Ars after ral Directed in by	Certif			City or Town, Sta	
ì	To the Hospital or Attending Physician: The law within 24 butus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my know and manner: On the basis of examination and manner stated.	wledge, death occurred at the time, date and place, ion and/or investigation, in my opinion, death occur	and due to the cause(red at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item	1 D	03	7/11/07
	Sta	te.	900 CATON ENE BA	TIMUDE MIN	PUSHA	PPEEP BRAR
	Registr		MAR 1 8 2009 Sentin S.	parl		

DHMH 17 Rev 1/200

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		For State Registrar		State of Ma	ryland /	-	artment of H <i>tificate of D</i>			giene Reg. No	71111	08451	
Physici	an	1. Decedent's Name	First, Middle, Las	1)		7	N.O.C.	^	2. Date of Dea Month	ath Da		3. Time of Death	
/Medic	al	4a. Facility Name (If r	ot institution, give	street and number)		70	4b. City, Town, or	Location of Deat	140cc)	40	County of Deat	h	
		The Johns H				- 146 - 11	Baltimore	City If Under 24 Hrs	8. Date of Birt	h		I/A hplace (State or Foreign	
Funeral Director		5. Social Security Nur 213-64-14	08	X M 2 \square F	(In yrs. last I	Yrs.	If Under 1 Year Months Days	Hours Min.	(Month, Day Feb 10	y, Year)	Coa	Maryland	
yland how at		Usual Residence of D 10a. State	Ob. County		10c. City, To	wn or Lo						10d. Inside City Limits	
ne Mar 28a-f s otified	Director	Maryland	N/	/A				ltimore		10- 0	tizen of What Co	1 Yes 2 No	
3a or 2	al Dir	10e. Street and Numb 201 5th Avei					10f. Zip-Code	21225		10g. Ci	U.S	,	
15-0036 72 hours after death with the Maryland "natural", or items 23a or 28a-f show idleal Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4		12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Was Decedent of Hir If Yes, specify Cubar 1 ☐ Yes 2 🕱 No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		14. Race - Ame Black, White Specify:		
5-0036 72 hours aft natural", or	eted		5. Decedent's Ed only highest grad		1	16a. Decedent's Usual Occupation (Give kind of work done during most of working					Kind of Business	Industry	
vithin within than "	Completed	Elementary/Secon		College (1-4 or 5	+)	life.	DO NOT use retired) Cus	todian			A.A. Cou	nty School	
nd 21 e filed wi ut Hygien other th	Be Co	17. Father's Name (Fi			·			18. Mother's Na	ame (First, Middle				
	70	40 15 11 11 11	Warren								lohnson	in Code)	
			a. Informant's Name/Relationship (Type. Print) Robin Johnson			19b. Mailing Address (Street and Number or Rural Rou 201 5th Avenue Baltimore, Maryl					or rown, state, 2	ip code)	
0 0 - =				Removal from State	ceme	etery, cre	osition (Name of matory or other place n Church Cen		Date 03/18/09	20c. L	ocation - City or Pasade		
Baltime permit. Pag Department Important: I any injury c		21. Signature of Fund	eral Service Licens		10	2	2. Name and Addres		eral Service.	P. A.			
				olications that caused		o not en	1300 Eu ter the mode of dyin	taw Place E g, such as cardia	eral Service, Baltimore, Mo ac or respiratory a	1212 rrest,	217	Approximate Interval Between	
Physician	r i	Immediate Cause (Fi		ne cause on each line	DXIC							Onset and Death	
/ /Medical Examiner		resulting in death)		Due to (a consequen	ce of):	200						
	iner	Sequentially list conditions if any, leading to imm	litions, nediate	b. Due to vas as	a consequen								
18760, X icate be executed physician and s the burial-transit	Examiner	cause. Enter Underlicause (Disease or in that initiated events resulting in death) La		c. Acute Due to (or as	CON consequen	in rod	sarcoi	J1600	Synd	10	we_		
8760, X cate be executed ohysician and s the burial-transit	edical E			melu b	2000	(λ	Sarcoi	dosis	>				
687 tificate tig phys		IE EEMALE:		·							-		
(ecords, P.O. Box 6) Iaw requires that the death certificate been signed by the attending I are should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown									23d. Date of de Month	Day Year	
cords, P.O. It is requires that the debeen signed by the a should be detached	by Pi	Part II. Other signific	ant conditions	ontributing to death b	ut not resultir	ng in the	underlying cause giv	ven in Part I.				the cause of death?	
ords equires en sigs sould b			-						1 🗆			obably 4 🗌 Unknown	
T e d d g	Completed								24a. Was autop perfo 1 XYes		death?	topsy findings available completion of cause of	
	Be	25. Was case referre examiner?	1	Hospital:			Othe	ar.	ath (Check only o				
Of Physic this of gral direct	은	1 ☐ Yes 2 🐪 N 27. Manner of Death	0	28a. Date of Injur	y 28	b. Time	of 28c. Injury	4 □ Nursing r	Home 5 Residence Reside			oify)	
//SION O Attending Ph death. ctor: After thi by the funeral	ation	1 Natural 2 Accident	5 Pending investigation			Injury		Yes 2 No				_	
Division of Vital I or Attending Physician: The after death. I Director: After this certificate of in by the funeral director, parts	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of injubulding, etc		, farm, st	reet, factory, office		28f. Location (City or Tox	Street a n, State	and Number or R e)	ural Route Number,	
To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Co			ysician: To the best of niner: On the basis of and manner sta	examination								
Vithin Vithin Comp	Me	29b. Signature and t	tle of certifier	10. 0		. 4'5	29c. License	number		29d. D	ate signed (Mont	h, Day, Year)	
		20 Name and add	#KIC	completed cause of c	leath (Item 20	MD Ba) (Time	Print)	- 000		1 A	iaich	11,2009	
		Bisra	- K.F	thrakar		MD	, ,	600	North Wo	lfe S	St, Baltime	ore, MD, 21287	
Sta Regist		31. Date filed (Month	Day, Year) R 1 8 200	2. Registra	ır's Signature	40	Mal						
rtegist		AMA	K T O TUO	o part		4							

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State Registrar

Box 68760, and P.0. has

Division of Vital Records, Director: After this d in by the funeral di within 24 hours a

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 **Physician** A M Ε. March 5:15 Lorraine Joyce /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Centreville Corsica Hills Nursing Home Queen Anne's 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min 1 □ M 2 1 F Months Davs Hours Director 24,1930 Maryland | 214-26-5624 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ∏Yes 2 X No Director Oueen Anne's Grasonville Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or Funeral 1023 Chester River Drive ILS.A 21638 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛣No ģ Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 8 N/A Bookbinder Reese Press Pages 1 and 2 should be filed venent of Health and Mental Hygicint: If item 27 is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Heath and Menta Important: If Item 27 is marked any Injury or other traumatic evonce. ပ Clifford Catherine Walhauser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William C. Joyce (Son) 1023 Chester River Drive Grasonville, Maryland 21638 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) T Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 103/19/09 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner GERRS Sequer trailly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ■ No 24a. Was an autopsy roberes mellit 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🖼 🔨 o 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

ORIGINAL

09-02107 Tejal Khajuria Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 08454 1- For State Certificate of Death Reg. No. Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Medical Examiner 0400 hrs March 15, 2009 Tejal K. Khajuria

4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8208 Swamp Rose Place Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Director 2 XF М 1985 220-15-8917 23 Oct 17, Maryland Usual Residence of Deceden 'n 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Yes 2 X No Laurel death with the Maryland Maryland Anne Arundel Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country items 23a or 20724 8208 Swamp Rose Place United States Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? White, etc. 1 X Never Married 2 Married Yes 2 X No jes I and 2 should be filed within 72 hours after of Health and Mental Hygiene.

If item 27 is marked other than "natural", o Widowed Δ Divorced If Yes, Give Year Yes 2 X No specify: Specify: Asian-Indian 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 5+ Student Education 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Kirit Khaiuria Bharti Μ. Goda 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kirit Khajuria/father 8208 Swamp Rose Place Laurel, Maryland 20724 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Pages 1 Burial 2 XCremation permit. Page:
Department o
Important: Donation 5 Other Specify: West Arundel Crematory 3/19/2009 Odenton, Maryland ²², Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road Odenton, Maryland 21113 21 inature of Funeral Service Licensee anita nomgo M00957 hart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interva **Physician** Between Onset and Medical Death _{a.} Asphyxia Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): b. Hanging Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED e attending physician for use as the burial Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live hirth 3 Ectopic pregnancy Year Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown а Unknown the ded Part II. Other significant conditions Records, P.O. contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? page certificate Yes 2 V No Yes 2 No Fo the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Other: DOA Nursing Home 5 Residence 6 ✔ Other: Scene this Inpatient 2 ER/Outpatient 3 1 Yes No After th 28a. Date of Injury (Month, Day, Year) FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work' 28d. Describe how injury occurred Certification: Subject found fully suspended within 24 hours after death.

To the Funeral Director: A completely filled in by the fu FOUND: Natural 5 Pending 1 Yes 2 ✔ No Mar 15, 2009 0346 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 8208 Swamp Rose Place, Laurel, MD determined (Specify) Single Family Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.F. March 15, 2009 5 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year, State Registrar

09-0168	39
William	Fran

7-01689 'illiam Francis Kre	Please Type or Print in Black Indelible Ink. Ensure All Copie State of Maryland / Department of Health and Mental H	-		0.01.5						
	1- For State Certificate of Death Registrar	Reg. No	2009	0845						
Physician/	1. Decedent's Name (First, Middle,Last)	2: Date of Death	3. Tim	e of Death						
ledical Examiner	William Francis Kreller 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deatleters	Month Day February 27, 2	1c. County of Death	11 hrs						
	3635 Kenyon Avenue Baltimore	1486-1	32 F = =							
Funeral	5. Social Security Number un 1 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs		M/DD/YYYY) 9. Birthplace							
Director	1X M 2 F 50 Yrs. Months Days Hours Mir	Feb 22,	1959 Maryla	.nd						
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Ir	nside City Limits						
ě	MD Baltimore		1 🗓	Yes 2 No						
the Maryland a or 28a-f show tified at once.	10e. Street and Number . 10f. Zip Code	. 10g. Ci	tizen of What Country?							
h the Na or setified	3635 Kenyon Avenue 21213	172.63	USA							
or items 23	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (S	S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bla White, etc.								
ter der ", or i	1 Yes 2 No 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify: white							
ours aft	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of		Kind of Business/Industry							
16 n 72 hour nan "natu ical Exan Sleted	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life, DO NOT use ret	- T								
5-0036 led within 72 hours. Hygiene. other than "naturithe Medical Exami	9 0 dry wall finisher 17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, Maide	home improve	ments						
21215-0036 ould be filed within 72 i Meiral Hygiene. s marked other than " ic event, the Medical. To Be Complet										
2, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland lealth and Meintal Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or		ode)							
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and Inportant: If item 27 is ruinjury or other traumatic.	John L. Kreller Jr/brother 3635 Kenyon Avenue Baltimore, MD 2. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location									
Baltimore, permit Pages I an Department of Hea Important: If iter injury or other tra	1 Burial 2 Cremation 3 Removal from State crematory or other place)	Date	. Location - City or Town, :	State						
Itim iit. Pa artimen ortant ry or c	4 Donation 5 Nother Specify: in State 21. Six Surger of Funeral Service Licenses 22. Name and Address of Facility									
Ba perm Depri Imju	21. Sinctore of Funeral Service Licenses Ronald Symptotic Director Ronald Symptotic Director Ronald Symptotic Director Baltimore, MD 212		altimore Str	reet						
Physician	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory arrest, sh		roximate Interval						
Medical xaminer	Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):			Death						
	b b b b b b b b b b b b b b b b b b b									
ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Cause. Enter Underlying Cause									
ted Insit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
and and	d.									
= s s s	UNPENDED									
D. Box 68760, the death certificate be by the attending physicicled for use as the burither Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy		3d. Date of delivery Month Day	Year						
OX (eath ce eath ce for use	4 Pregnant at time of death 5 Other (Specify)									
hed thed	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cau	se of death?						
i, P.O ires that to signed by the detact		1 Yes 2	No 3 Probably	4 Unknown						
Records, The law require: frate has been sig, page 2 should be		24a. Was an autopsy	24b. Were autopsy fi prior to completi							
Recorder The la		performed? 1 ✓ Yes 2	death? No 1 ✓ Yes	2 No						
ican: The certificate rector, page	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other Nursi									
> 2 2 2 0	1 Yes 2 No	ng Home 5 Resid	lence 6 🗸 Other: Scene							
on of anding Pl ath. r: After he funera	1 Natural 5 Pending (Month, Day, Year) 1 Yes 2 No	200. Doddingo How II	yary occurred							
Division of Vital lat or Attending Physician: is after death. al Director: After this certified in by the funeral director artification: To Be	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.		and Number or Rural Rou	te Number, City						
Division o Hospital or Attending 24 hours after death. Fameral Director: After step filled in by the fune ital Certification:	4 Homicide determined (Specify)	or Town, State)								
	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and one)			e(s)						
To the He within 24 To the Fu completel	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo									
	Call 1 1 1 0.C.M.E.	1	bruary 27, 2009							
	30. Name and address of person who completed cause of death (Item 23a)	<u></u>								
	Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21 31. Date filed (Mogth, Day, Year) 32. Registrar's Signature	201	· · · · · · · · · · · · · · · · · · ·							
State Registrar	31. Date filed (Month, Day, Year) 32. Fegistrar's Signature ARR 18 2009									

			Pleas	e Type or Pri					All Copies d Mental Hy		_		
	a.		T - For State Registrar	State of Mi	ai yiai iu /		rtificate of		u Mentai my	Reg. No	.2009	08456	
	Physici	an	1. Decedent's Name (First, Middle, Helen	Last)	К	ova	lick		2. Date of De Month March	eath		3. Time of Death 10:00 PM.	
-	/Medic Examin		4a. Facility Name (If not institution,	_			4b. City, Town, o			40	. County of Death	1	
agented The	Funeral			6. Sex 7. Ag	e (In yrs. last b	irthday)	Dunda	If Under 24 I	rs. 8. Date of Bi		Baltimo	oplace (State or Foreign	
	Director		188–12–2612 Usual Residence of Decedent	1□ M 2 X 0 F	87	Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Birth August 6, 1921 9. Birthplace (State Country) Pennsylvar						
	aryland show	ř	10a. State 10b. County	morro	10c. City, Tov	wn or Lo			<u>-</u>			10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
	h the M	Funeral Director	Maryland Balti 10e. Street and Number	more			10f. Zip Code			10g. C	itizen of What Cou		
	s 23a c	eral	7923 Trappe Road		Ever in II C	10		1222	(Specify Vas or N		USA 14. Race - Amer	ican Indian	
980	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ant, the Madical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ XVidowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 □ Yes 2 ☑ If Yes, Give Year or Dates:	No		was Decedent of the first of t		' (Specify Yes or No uerto Rican, etc.)	J-	Black, White		
21215-0036	n 72 ho "natur	Completed	15. Decedent' (Specify only highest	grade completed)		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of	working	16b. h	Kind of Business/I	ndustry	
212	d withi /giene. er than	Comp	Elementary/Secondary (0-12) 11 years	College (1-4or !	5+)		nstress			_	ewing		
land	d be file ental Hy ked oth ic event	To Be (17. Father's Name (First, Middle, L William H. Gradw						Name (First, Middle .a Bolton	, Maidei	n Surname)		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examiner must be notified at once.	-	19a. Informant's Name/Relationsh Viola D. Sanders		19b. Mailing Address (Street and Number or Rural Route Number, City or To 618 Fuselage Avenue, Essex, Marylan						(ip Code) 221		
Baltimore,	Pages 1 a ment of He ant: If Item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 4 ☐ Donation 5 ☐ Other (Sp				sition (Name of matory or other pla Cremator)		rch 19, 2009		ocation - City or T		
Balt	permit. Departimport any inj		21. Signalure of Funeyal Service L	censee	elles	/ cc	nneily 110 Solle	uneral ers Poir	Home Of I	ound ound	alk,P.A. alk, Md.	21222	
	Physician		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	omplications that caused nly one cause on each li	ne.			-	RCTO	arrest,		Approximate Interval Between Onset and Death	
1	/Medical		disease or condition resulting in death)	Due to (or as	a consequence	_	MAC	ONPA	100/100				
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	a consequence	e of):							
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6876	ificate b g physic is the b	edica		d									
O. Box	Attending Physician: The law requires that the death certificate be executed refath. roteath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ★No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal dea	Fetal death 3 Ectopic pregnancy					23d. Date of delivery Month Day		
ds, P.	uires that to n signed by Id be deta	by	Part II. Other significant condition	s contributing to death b	out pot resulting		nderlying cause gi	ven in Part I.		tobacco Yes 2		the cause of death?	
of Vital Records,	e faw requir has been si e 2 should I	Completed				-			24a. Was		24b. Were aur	topsy findings available ompletion of cause of	
talF	an: The tificate tor, pag	Be Cor	25. Was case referred to medical			<u> </u>		26. Place of	1 ☐ Yes	2. M N	o 1 Yes	2 No	
of Vi	hysici this cer		examiner? 1 ☐ Yes 2 Mo		ent 2 ER/C		IL 3 L DOA	her: 4 🗆 Nursir	g Home 5 Res	idence		rify)	
ion	nding P ith. r: After i e funera	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investige		ury 28b. uy, Year)	. Time o Injury	Wo	ıryat rk? ∐Yes 2 ∐No	28d. Describe	how inju	ury occurred		
Division		Certification: To	3 □ Suicide 6 □ Could n 4 □ Homicide determi	28e. Place of In	ury - At home, c. (Specify)	farm, sti	eet, factory, office		28f. Location City or To			ral Route Number,	
7	the Hospital or hin 24 hours afte the Funeral Dir mpletely filled in	Medical (Physician: To the best xaminer: On the basis of and manner st	of examination a								
	To th within	Me	29b. Signature and title of certifier	sh Pan	mel	Ar		se number 30133	3	29d. D	ate signed (Month		
			30. Name and address of person v	MINIGLY /	40	1	OTT BEL	con 1	20 BAG	-T1 N	nore 1	10 21220	
	Sta Registi		31. Date filed (Month, Day, Year)	2. Regist	rar's Signature	for	A D						
			PIAIL I . C	- JT									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #30 per DVR 8889 3.18.09 TT *#30 per DVR g889 3.18.09 TT State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 1 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2<u>009</u> Month Year **Physician** March 17, Lenora Kline 8:15 A^{M} /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 8000 Charlesmont Road Dundalk If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 1 F 212-44-2547 West Virginia December 22,1944 64 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Baltimore Dundalk Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 USA 8000 Charlesmont Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White <u>م</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Waitress 11 years is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event Be Simon McCauley Louise Scheitlin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8000 Charlesmont Road, Dundalk, Maryland Robert Kline Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 20 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory Baltimore City, MD. 4 ☐ Donation 5 ☐ Other (Specify) 2009 Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 21. Signature of Funeral Service Licensee witho 23a. Part1. Enter the disease, shock, or heart failure. L complications that caused the death. Op not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the IF FEMALE asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 200 No
9 ☐ Unknown ģ Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 22 No certificate 1 ☐Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier CD

State Registrar Blvd. 708 Baltimore, MD 21224

MD 1005 N point

30. Name and address of person who completed cause of death (frem 23a) (Type, Print)

Diaa Youssef Mikhail,

8

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $2\,\bar{0}\,0\,9$ Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Krauch **Physician** 1029 PM March 2009 12 orraine /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 63 Maryland 220 58 1580 10/19/1945 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State 28a-f show notified at N/A 1 X Yes 2 No Baltimore Director Maryland 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number ö the Medical Examiner must be 608 E. Jeffrey Street 21225 U.S.A. 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Was Decedent Ever in U.S. Armed Forces? or items 11 Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☐
If Yes, Give
Year or Dates: 1 X Never Married 2 Married 2 X No 1 Yes 2 X No Specify Specify. þ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Assembly Worker / Packer Tool Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William John Krauch Gertrude Kirby ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sherry Johns / sister 509 Vista Avenue Glen Burnie, Maryland 21061 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Department of H
Important; If ite
any Injury or oth 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 4 Donation 5 Other (Specify) 03/17/2009 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 4001 Ritchie Highway_ Part 1. Enter the disease or complications that caused the shock, or heart failure. List only one cause on each line. nominoushi Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) 124515 Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Unknown by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò -AILORE 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? COLETES 24a. Was an autopsy 2 X No 1 Yes 1 Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death

1 A Natural

2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) 24 hours Decritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hou

To the Fune

completely fi (check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Day, Year) 29c. License number 29b. Signature and title of certifier 2003 KES 000

State Registrar 30. Name and

31. Date filed (*Month*, *Day*, *Year*) **MAR 1 8 2009**

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

600 North Wolfe St. Baltimore, MD, 21287

address of person who completed cause of death (Item 23a) (Type, Print)

27/00/95

32. Registrar's Sig

09-02036 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Aleksandr Kushnirov State of Maryland / Department of Health and Mental Hygiene 08459 2009 1- For State Certificate of Death Registrar Rea. No 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ March 12, 2009 1038 hrs Medical Examiner **KUSHNIROV** ALEKSANDR 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death University Hospital **Baltimore** N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days Hours oreign Director Country) UKRAINE 213-37-6881 59 1 X M 2 F 07/28/1949 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Yes 2 X No 28a-f shov BALTIMORE REISTERSTOWN notified at once. MD the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 SHELTON COURT 21136 with Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces White, etc. Never Married 2 X Married Yes Yes, Give Year Yes 2 X No specify: Specify: WHITE ut of Health and Mental Hygtene.

11: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner. 3 Widowed Divorced þ imore, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ELEVATOR MECHANIC 12 **ELEVATOR** 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) **KUSHNIROV** Be GRIGORIY MARIYA VERNAYA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD RITA SOSNINA / WIFE 5 SHELTON COURT, REISTERSTOWN, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, BALTIMORE HEBREW 1 X Burial 2 Cremation 3 Removal from State Department of Important: I 03/15/2009 REISTERSTOWN, MD Donation 5 Other Specify: SOL LEVINSON & BROS , INC. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death a. Hanging Immediate Cause (Final disease kamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED attending physician or use as the burial The law requires that the death certificate be Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live hirth Fetal death Month Day Year past 12 months Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown q Unknown the 23e. Did tobacco use contribute to the cause of death? Ó Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ ۵. Yes 2 ✔ No 3 Probably 4 Unknown ted 24a. Was ar 24b. Were autopsy findings available Complet autopsy prior to completion of cause of has page 2 performed? death? certificate Yes 2 V No No 25. Was case referred to medica 26.Place of Death (Check only one) Be Other₄ examiner? Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 this 1 🗸 Yes ပ After 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Mar 12, 2009 Subject hanged himself 0000 hrs Natural Yes 2 V No Pending death. in by the 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 22 South Green street, Baltimore, MD determined (Specify) Hospital

Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director:

filled

29b. Signature and title of certifier Ling Li, MD 31. Date filed (Month State

cal

Homicide 29a. Certifier 1

30. Name and address of person who completed cause of death (Item 23a) 111 Penn Assistant Medical Examiner

and manner stated

March 13, 2009

29d. Date signed (Month, Day, Year)

29c. License number

O.C.M.E.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and injury or other traumatic event and injury event and	Be Completed by Funeral Director	4a. Facility Name (If not institution Baltimore Wash 5. Social Security Number 455-50-8390 Usual Residence of Decedent 10a. State 10b. County Maryland Anne 10e. Street and Number 1347 Brenda Ro 11. Marital Status 1 Never Married 2 Maryland Widowed 4 Divorced 15. Deceder	Arundel 12. Was Decedarised For IX 1/28 Square Squ	lical C 7. Age (In yrs. 73	last birthday) Yrs.	Glen If Under 1 Year Months Days	or Location of Death Burnie If Under 24 Hrs. Hours Min.		rth	Anne 9. Birth	Arunde1		
Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanciant countries any injury or other traumatic event, the Medical Evanciant countries and injury or other traumatic event, the Medical Evanciant countries and injury or other traumatic event, the Medical Evanciant countries and injury or other traumatic event, the Medical Evanciant countries and injury or other traumatic event, the Medical Evanciant countries and injury or other traumatic event, the Medical Evanciant countries and injury or other traumatic event, the Medical Evanciant countries and injury or other traumatic event, the Medical Evanciant countries and injury or other traumatic event, the Medical Evanciant countries and injury or other traumatic event, the Medical Evanciant countries and injury or other traumatic event, the Medical Evanciant countries and injury or other traumatic event, the Medical Evanciant countries and injury or other traumatic event, the Medical Evanciant countries and injury or other traumatic event, the Medical Evanciant countries and injury or other traumatic event, the Medical Evanciant countries and injury or other traumatic event, the Medical Evanciant countries and injury or other traumatic events.	Be Completed by Funeral Director	Baltimore Wash 5. Social Security Number 455-50-8390 Usual Residence of Decedent 10a. State 10b. County Maryland Anne 10e. Street and Number 1347 Brenda Ro 11. Marital Status 1 Never Married 2 Maryland 15. Deceder (Specify only higher)	Arundel 12. Was Deceder Armed Form	7. Age (In yrs. 73	last birthday) Yrs. ty, Town or Lo	Glen If Under 1 Year Months Days	Burnie	O Date of Bir	rth	Anne	Arunde1 pplace (State or Foreign		
Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar count be natified at once. To Be Completed by Funeral Director	Be Completed by Funeral Director	5. Social Security Number 455-50-8390 Usual Residence of Decedent 10a. State 10b. County Maryland Anne 10e. Street and Number 1347 Brenda Ro 11. Marital Status 1 Never Married 2 Mary 15. Deceder (Specify only higher	6. Sex 1 DXM 2 F 7 Arunde1 Arunde1 12. Was Decedarmed For TY Yes 2 (1798.) Gives 1798.	7. Age (In yrs. 73	last birthday) Yrs. ty, Town or Lo	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Bir (Month, Da Nov 15	rth ay, Year) , 1935	9. Birth	nplace (State or Foreign		
Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar count be natified at once. To Be Completed by Funeral Director	Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Anne 10e. Street and Number 1347 Brenda Ro 11. Marital Status 1 Never Married 2 Mary 15. Deceder (Specify only higher	Arundel Arundel 12. Was Deceed Armed Form	73	Yrs. ty, Town or Lo	Months Days		8. Date of Bir (Month, Da Nov 15	rth ay, Year) 1935	9. Birth Cou	nplace (State or Foreign intry) 'exas		
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Department of Health and Mental High 27 is marked off any injury or other traumatic even once.	n n	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced 15. Deceder (Specify only higher	12. Was Deced Armed Ford ried 17 Yes 2	dent Ever in U.		10f. Zip Code			10g. Citizen o	of What Cou	intry?		
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any injury or other traumatic even once.	n n	3 Widowed 4 Divorced 15. Deceder (Specify only higher)	If Yes. Give	ces?	.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No Rican, etc.))- 14. F	Race - Ameri Rack, White,			
Important: if Item 27 is marked oft any injury or other traumatic even one.	n n	(Specify only highe	•	e		1⊡Yes 2 X DNo			Spe				
Important: if Item 27 is marked oft and any injury or other traumatic even once.	n n	Elementary/Secondary (0-12)	t's Education st grade completed)		16a. Dece	dent's Usual Occu	ipation o during most of work ed)	ing	16b, Kind of	16b. Kind of Business/Industry			
Important: if Item 27 is marked oft and any injury or other traumatic even once.	n n		College (1-4	4or 5+)			^{₃a} , Intelligen		Unit	od St:	ates Army		
Important: If Item 27 is marked any injury or other traumatic er once.	n o	17. Father's Name (First, Middle,	Last)			LIILALY .	18. Mother's Name				aces Almy		
any injury or other training of the training of training of the training of the training of the training of th	_	James B. Lile	,				Derli	,		<i>'</i>			
Important; if Item 27 is any injury or other tra	-	19a. Informant's Name/Relations			19b. Mailir	ng Address (Stree	t and Number or Run				p Code)		
sician edical		Siri Liles/wif	e			Brenda			aryland 21144				
ician dical		20a. Method of Disposition	_	20b. F		sition (Name of natory or other pla		Date	20c. Locatio				
ician dical		1 ABurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		tate			ery 3/16,	/2009	Crownsv	7ille.	Maryland		
ician edical		21. Signature of Funeral Service		12									
dical		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. M00957 M00957 M00957											
ical			complications that car								Approximate Interval Between		
_		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition CORALIE HERRY DISEASE Approximate Interval Between Onset and Death									Onset and Death		
iner		resulting in death)	a.	r as a conseq									
		Sequentially list conditions. b. CONGESTIVE HEART TRILYING											
ine.	E E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
rial-transit Examiner	хап	that initiated events resulting in death) Last C. Due to (or as a consequence of):											
priysician and s the burial-transit dical Examir	<u>8</u>	HTRIAL FIBRILLATION											
0 8 0				11									
detached for use a Physician/M		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregna		∃Ectopic pregnan	27		23d. [Date of deliv	ery		
ed for	25	in the past 12 months? 1 ☐Yes 2 ☐No		ant at time of d		Other (specify)	Cy		'	Month	Day Year		
stach Phys		9 ☐ Unknown											
be de		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did toba								acco use contribute to the cause of death?			
should be o	3	11 / - 12						138	1 Yes 2 No 3 Probably		bably 4 🗌 Unknown		
2 sh	로	HILLO INJKO.	(10) SM					24a, Was		o. Were auto	opsy findings available ompletion of cause of		
page 2 should be o	١ إ	C02D						perfo 1 ☐ Yes	rmed? 2 XNo	death? 1 ☐ Yes			
In scenificate has a director, page 2 si		25. Was case referred to medica examiner?					26. Place of Death						
F F	0	1 ☐ Yes 2 ☐XNO			ER/Outpatier	IL 3 LI DOA	her: 4 ☐ Nursing Ho	me 5 Resi	dence 6 □C	ther (Specia	fy)		
funeral di	5	27. Manner of Death 1 Natural 5 ☐ Pendir	9 '	f Injury , <i>Day, Year)</i>	28b. Time of Injury	Wo	rk?	28d. Describe I	how injury occi	urred			
the f	2	Accident investignment investi	not be]Yes 2 □No						
led in by the funeral Certification: T		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (SCity or Town)						Street and Nur vn, State)	nber or Rura	al Route Number,			
one runeral brector: After the completely filled in by the funeral Medical Certification: T		29a. Certifier 1 Certifyii (Check only one) 1 Medical	ng Physiclan: To the b Examiner: On the bas and manne	sis of examina	wledge, deat tion and/or in	h occurred at the vestigation, in my	time, date and place, opinion, death occur	and due to the red at the time,	cause(s) and date and place	manner as s e, and due to	stated. o the cause(s)		
Comp	מוני	29b. Signature and title of certifie	1 Ocho		lan	29c. Licen	se number		29d. Date sign	-	<u> </u>		
,1	Medic	MMMORE	in Jili	MAR	1017	レプ	11711		03/11	126	70		
5 ⁴¹	Medic		who completed cause							1	-		
State Registrar	O DOM	30. Name and address of person 31. Date filed (Month, Day, Year)	MENYOU I	of death (Item	80811	Print)	KDRIVES	uite 12	18 (JEH	ByKN	INE MOZIO		

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09-02086

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ulius Lee, Jr.		For State Registrar	e of Maryland / D	epartment of Certificate of		Mental H	ygiene _{Reg}	No. 201	19 0846		
Physicia Medical Examin	n/	 Decedent's Name (First, Middle, La 	Lee Jr.			¥ 15.	Date of Death Month	Day Year	3. Time of Death 0231 hrs		
¹ 41		4a. Facility Name (if not institution, g		. 4	b. City, Town, or L	ocation of Death	March 14, 2	4c. County of Dea			
Funeral	4	Sinai Hospital 5. Social Security Number 6. 9	Sex 7. Age (In	yrs. last birthday)	Baltimore If Under 1 Year	If Under 24Hrs	. 8. Date of Birth	(MM/DD/YYYY) 9. B	irthplace (State or Foreign		
Director			M 2 F	32 Yrs.	Months Days	Hours Min	Feb. 28	71977	Maryland		
any	-	Usual Residence of Decedent 10a. State 10b. County	- 10c.	City, Town or Locati	on nil		-		10d. Inside City Limits		
Maryland 28a-f show 1 at once.	호	Maryland	NA		Bûlt 10f. Zip Code	imore 1216		g. Citizen of What Co	1 Yes 2 No		
with the Maryland ns 23a or 28a-f sho be notified at once	Director	3329 Gwyn	w Falls Po	erkway	2	1216	100	USA	- Introduction		
ath with items 23	Funeral	11. Marital Status 1 Never Married 2 Marrie		If Yo	s Decedent of Hisp es, specify Cuban,			14. Race - Ame White, etc.	erican Indian, Black,		
72 hours after death with the Maryland n "matural", or items 23a or 28a-f she all Examiner must be notiffed at once	ō, Fu		ed If Yes, Give Year or Dates:		Yes 2 No			Specify:	ack		
72 hours	eted	15. Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or 5+)	during me	t's Usual Occupationst of working life. I	DO NOT use reti	red)	16b. Kind of Busines:	s/Industry		
215-0036 be filed within ntal Hygiene. rked other tha	Completed	17. Father's Name (First, Middle, Las	st)	H	one In		(First, Middle, M	aiden Surname)			
214 be fill ntal F	Be	Julius Lee		1000		Rhond	a Mad	dox			
	٩	19a. Informant's Name/Relationship Rhonda Maddi		196. Mailing		s Falls		per, City or Town, Sta	ite, Zip Code) 21 imar Maryland		
Fe, s I an of Hea If ite		20a. Method of Disposition 1 Surial 2 Cremation 3	Removal from State	20b. Place of Dispos crematory or oth	er place)	· _	Date	20d. Location - City			
Baltimore, permit. Pages I an Department of He Important. If ite injury or other trees.	1	4 Donation 5 Other Special Signature of Funeral Service Lice			ame and Address	of Facility	Ker Fu	nem / Ha	nie Marylard ne PA		
ന ഉദ്ളള Physician	1	23a. Part I. Enter the disease, or con	polications that caused the		oe mode of dving.		AW: B		Md. 21229 Approximate Int-rval		
/Medical xaminer		failure. List only one cause on Immediate Cause (Final disease							Between Onset and		
	1	or condition resulting in death) Sequentially list conditions,	Due to (or as a conseque	nce of):							
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conseque	nce of):		•					
		events resulting in death) Last	Due to (or as a conseque						0.00		
60, te be execut ysician and burial - tra	edical	UNPENDED	X _{AMENDED} 23a, _I		0 4/14/0	9 TT					
	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	₂ Fe	tal death 3	Ectopic pregna	ancy	23d. Date of delive Month	ery Day Year		
Box e death c the atten	Physician/M	1 Yes 2 No 9 Unknow	yn g Unknown	or death 5 Ot	ner (Specify)						
i, P.O. B ires that the d signed by the		Part II. Other significant conditions Hypertensive left ventric	-	-					to the cause of death?		
Division of Vital Records, P.O. Box 6876 hin 24 hours after death certificat hin 24 hours after death. The law requires that the death. The Funeral Director: After this certificate has been signed by the attending phapetely filled in by the funeral director, page 2 should be detached for use as the	Completed by			-			24a. Was a autops	y prior to	autopsy findings available o completion of cause of		
tal Rec		25. Was case referred to medical	T		26 Diago	of Death (Check	perform 1 ✓ Yes 2				
1 of Vital Recing Physician: The After this certificate funcral director, page	ğ O	examiner? 1 ✓ Yes 2 No	1	2 Z ER/Outpatient	3 DOA	Other Nursi		Residence 6 Oth	ner:		
Sion of Attending Pi death. ctor: After y the funera		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	28b. Time of I	· · · ·	yatWork? es 2 No	28d. Describe h	ow injury occurred			
Division pital or Attendit ours after death. teral Director: A	Certification:	2 Accident Investiga 3 Suicide 6 Could no	ot be 28e. Place of Injury	- At home, farm, stree	et, factory, office bu	uilding, etc.	28f. Location (Stor Town, St		Rural Route Number, City		
Divis To the Hospital or A within 24 hours after To the Funeral Dire		4 Homicide determing 29a. Certifier 1 Certifying Phys	ician: To the best of my kno	owledge, death occur	red at the time, dat	te and place, and	d due to the cause	e(s) and manner as st	tated.		
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examin 29b. Signature and title of certifier	er:On the basis of examina and manner stated.	ion, in my opinion, 29c. License		at the time, date a	nd place, and due to 29d. Date signed (A				
	_	Quest			O.C.N			March 14, 2009			
N	İ	30. Name and address of person wh Ana Rubio MD. Assist	o completed cause of death ant Medical Examine		Street, Baltimo	re, MD 2120	<u>_</u> 1				
Sta Registr	_	31. Date filed (Month, Day, Year)	32. kegistrar's S								

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			For State Registrar	State of	Marylan		artment o rtificate			ınd M	ental Hy	giene Reg. No2 (109	08462
			Decedent's Name (First, Middle	le, Last)							2. Date of De	ath		3. Time of Death
	Physici /Medic		Louise Lundbe	rg							Month March	11, 20	009 ^{Year}	12:15 PM
,	Examin		4a. Facility Name (If not institution	_			4b. City, To			f Death			inty of Deat	h
			Fairhaven Nur		r '. Age (In yrs. i	(not hirthday)	Sykes If Under 1		le If Under 2	04 Hre	8. Date of Birt		roll	100
	Funeral Director		216-22-9798 Usual Residence of Decedent	1 M 2 M F	96	Yrs.			Hours	Min.	(Month, Da) Feb 5,	y, Year)	Co	hplace (State or Foreign untry) Mexico
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	tor	10a. State 10b. County MD Carr			y, Town or Lo kesvil								10d. Inside City Limits 1 ☐ Yes 2√ No	
	irec	10e. Street and Number				10f. Zip Co	ode				10g. Citizen	of What Co	untry?	
	rai	9700 3rd Avenu					784				US			
	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Mari 3 ☎ Widowed 4 □ Divorced	If Yes Give	ces? 2 X INo	1	Was Deceden If Yes, specify 1 ☐ Yes 2X		panic Orig , Mexican, Specify:	jin? (Spe , Puerto I	cify Yes or No Rican, etc.)		Race - Ame Black, White ec <i>ify:</i> wh	_	
Maryland 21215-0036	n 72 ho "natur edical	Completed by	(Specify only highe	nt's Education est grade completed)		(Give	dent's Usual C kind of work of DO NOT use i	done du		of workin	ng	16b. Kind o	f Business/	Industry
212	d within giene. r than	dmo	Elementary/Secondary (0-12)	College (1-	4or 5+)		school		ache	r		liter	ature	education
פ	al Hyg	BeC	17. Father's Name (First, Middle,	Last)				1	8. Mother	's Name	(First, Middle,			
<u>ya</u>	ould b Ment larked	70	Martin Mullen								uthrey			
	nd 2 sh lith and 27 Is m r traum		19a. Informant's Name/Relations Martin Lundber			19b. Mailii 4350	ng Address <i>(S</i> East.	treet an Bou	d Numbe ilder	r or Rura Rid	Route Numberge Phoe	er, City or To	<i>wn, State, 2</i> AZ 8.	ip Code) 5044
Baltimore,	Pages 1 and 2 nent of Health int: If item 27 I		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (S	3 □Removal from S		lace of Dispo emetery, cre	osition (Name matory or othe	of er place)	1 1 1 6 4	D	ate	20c. Location	on - City or	Town, State
Balti	permit, Departn Importa any Init		21. Sign Aure of Fineral Jervice	Licensee Di	rector	B	altimo:	re,	MD	<u> 2120</u>	1		imore	Street
j	Physician /		23a. Pat1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Reval failure Due to (or as a consequence of):										Interval Between Onset and Death	
	Examiner		Sequentially list conditions	b.	r as a consequ	derice or):								
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	uence of):	ce of):									
Ó,	te be executed ysician and e burial-transit		that initiated events resulting in death) Last	c Due to (o	C. Due to (or as a consequence of):									
68760,	cate be physici the bu	dical		d									_	
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 Fetaint at time of de	death 3	⊒Ectopic pregr ☑Other <i>(speci</i>						Date of deli Month	very Day Year
α.	ires that signed by	by	Part II. Other significant condition		ath but not resu	a a		se given	in Part I.		23e. Did to			the cause of death?
Records,	w requ	leted	11	,		0. 00	70.3	<u> </u>	stuse		24a. Was			
Re	The la	Completed	Cosmitive	e impair	rment						autop perfo		prior to death?	topsy findings available ompletion of cause of 2 No
Vita	clan:	Be C	25. Was case referred to medica examiner?	ıl				2	26. Place	of Death	(Check only o		10103	2 110
7	this or	P	1 Yes 2 No		patient 2			Other:	412 Nur		ne 5 🗆 Resid			eify)
ono	ding Phys h. After this funeral di	ion:	27. Manner of Death 1 Natural 5 ☐ Pendin 2 Accident investi	19	, Day Year)	28b. Time o Injury	f 28c.	Injury a Work?	at es 2 ⊡ N		8d. Describe h	ow injury oc	curred	
Division or	l or Atten after deat Director: I in by the	Certification:	2 Accident Investig	not be 28e. Place o	I of injury - At ho g, etc. <i>(Specif</i>)					_	8f. Location (S City or Tow	treet and Nu n, State)	ımber or Ru	ral Route Number,
	Hospita 4 hours Funeral tely filled		29a. Certifier 1 ✓ Certifyir (Check only one) 2 ☐ Medical	ng Physician: To the b Examiner: On the bas and manne	sis of examinat	wledge, deat tion and/or in	h occurred at to	the time my opir	, date and nion, deat	d place, a	and due to the ed at the time,	cause(s) and date and plac	manner as ce, and due	stated. to the cause(s)
)	To the within 2 To the complet	Medical	29b. Signature and title of Certifie	WO .				icense n	number 549			29d. Date sig		, Day, Year) 1009
			0 1111011	an MD	1645	Libe	Ay R.	4	Elo	ders	burg	MD	21	784
	Sta Registr	_	31. Date filed (Month, Day, Year) MAR 18	2009 Det	gistrar's Signa	1. 40	ale							
				7		-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 12:05 PM 3 Steven 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and nu Examiner timore 8. Date of Birth (Month, Day, Year) Jan 18, 1926 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1 X M 2 □ F 83 Director 219-10-8088 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Baltimore 1X Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5009 Frankford AVenue Funeral 21206 USA 14. Race Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 27 No Specify: Specify: þ black 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Steve Layton ပ <u>Hattie Kelley</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana White/niece 1516 Kennewick Road Baltimore, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☒Other(Specify) in state 21. Signalus of Ronald S. Wady, State and Address of Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 10 **Physician** disease or condition resulting in death) MID /Medical Due to (or as a consequence of): Examiner Coronory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical signed by the attendin t be detached for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Jura after death.

leral Director: After this certificate has been si filled in by the funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No decobibes 24a. Was an autopsy perform Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15ccertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours a

Duniel 31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

Loward Registrar's Signatu 32

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 18 2009

WO)

29c. License number

Erha

Place

29d. Date signed (Month, Day, Year)

3-10.09

2/2/2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5, 20b-c, perFh 8889 3/25/09 TT
State of Maryland / Department of Health and Mental Hygiene 0 9 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 17, Day 2009 **Physician** Loane Virginia 4:50 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Eldercare- Heritage Center Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🂢 F Months Days Hours Min September 3, 1924 217-12-6613 84 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Director 1 ☐ Yes 2X No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P 7406 Waymouth Way 21222 Items 23a USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 K No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 No Specify by Specify: White 3 Widowed 4 Divorced Completed The Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, Inc. Ma. Once. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 8 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edmund L. Jacobs Helen Pettingill ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles M. Loane Husband 7406 Waymouth Way, Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State W Burial 2 ☐ Cremation 3 ☐ Removal from State Mar. 20, 2009 Timonium, MD Dulaney Valley Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 10 Sollers Point Road, Dundalk, MD. 21222 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line.

RESPIRATORY FAILURE Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed sician a burial-t Division of Vital Records, P.O. Box 68760, Physician/Medical phys the attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Whiknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 certificate ha rector, page 2 autopsy 1 ☐ Yes 2 🗍 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Peath (Check only one) examiner? Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral dir Nursing Home 5 Residence 6 Other (Specify) this. 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: , 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number State Registrar MAR 18 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#5perFH.G890.4/15/09.WS
State of Maryland / Department of Health and Mental Hygiere ()

08465 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2009 915 AM Physician Frank Joseph Lavender /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 8325 Peachwood Drive Howard Jessup If Under 1 Year | If Under 24 Hrs. S217-27-17643 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 07/17/1927 Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1**⊠**M 2□ F 81 Yrs. Director Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State ir than "natural", or Itema 23a or 28a-f ehow Tre Medical Exeminar must be notified at 1 Yes 2 No Director Jessup Howard Marvland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8325 Peachwood Drive 20794 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a any njury or other traumatic event, the Madical Examinations once. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 (25 Yes 2 ☐ No If Yes, Give Year or Dates: WW II 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver Oil Company 7th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Lavender Marie Tracev ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 555 Grays Creek Road Pasadena, Maryland 21122 Theresa Ayres / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 03/18/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee Baltimore, Maryland 21225 4001 Ritchie Highway ranurouse 23a. Part1. Enter the disease, or conshock, or heart faifure. List only plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician acute myocardial disease or condition resulting in death) Immellate /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ped 1 ☐ Yes 2 ☐ No certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: No the rocess within 24 hours after death.

To the Funerel Director: After this certification that the funeral director. Be 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospitaf: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 2 1 Yes 2 No 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D25611 Can mu Mar 17, 2009

Registrar

State

Frank Lavender

31. Date filed (Month, Day, Year)

. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fra E. Kaplan, M.D. 7845 Oakwood Rd #300 Glen Burnie, Md 21061

Certificate of Death

2. Date of Death

Day

2009

24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2【□No performed: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Month

Day

Year

08466

3. Time of Death

2145

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 No

Country

14. Race - American Indian, Black, White, etc.

Asian Indian

India

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one)

28b. Time of

5 Pending investigation

6 ☐ Could not be

determined

29d. Date signed (Month, Day, Year) March 16, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Satyam Shan Holy Cross Hospital 1500 Forest Glen Road Silver Spring, MD 20910 31. Date filed (Month, Day, Year) --

1 ☐ Yes 2 ☐ No

29c. License number

D68096

20

il Director: A

State Registrar

Medical

27. Manner of Death

1 XVatural

2 Accident

4 ☐ Homicide

29b. Signature and title of certifier

3 ☐ Suicide

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

09-02082 Tod Me

Please ⁻	Type or Print in	Black Indelible Ink	Ensure Al	l Copies Are Legible.
	State of Marylar	nd / Department of H	ealth and Mo	ental Hygiene

dd Mitchell		State of Maryland / Department of Certificate of		Hygiene Reg.	2009	0846					
Physicia edical Exami	an/	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death Month	Day Year	Time of Death					
Car Exami	ilei		b. City, Town, or Location of Dear	March 13, 2	4c. County of Death Baltimore Count						
		Sudbrook Tunnel at Greenwood Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Pikesville If Under 1 Year If Under 24Hi	lace (State or							
Funeral Director		220-74-8979 XX M 2 F 46 Yrs.	Months Days Hours Mi		Foreign	try) MD					
'n		Usual Residence of Decedent				0d. Inside City Limits					
d now any		10a. State 10b. County 10c. City, Town or Location 10h. State 10b. N/A Baltimor				X Yes 2 No					
rith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country	y?					
h the M 3a or 2 otified		1822 Ruxton Avenue	21216		USA						
ath witl	Funeral	1 v √Never Married 2 Married Armed Forces? If Ye	s Decedent of Hispanic Origin? (\$ es, specify Cuban, Mexican, Puerl		14. Race - America White, etc.	n Indian, Black,					
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked ofter than "natural", or items 23a or 28a-f she rether traumatic event, the Medical Examiner must be notified at once.	by Fu	Yes 2XXNo	Yes 2 X No specify:		Specify: Blac	:k					
hours "natur	ted t	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent	t's Usual Occupation (Give kind of ost of working life. DO NOT use re		6b. Kind of Business/Ind	ustry					
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212 ould be I Menta marke ic even	То Ве		Address (Street and Number of	<u> </u>		ip Code)					
MD nd 2 sho alth and m 27 is aumat			Ruxton Aven		20c, MD 212						
Baltimore, MD oemit. Pages 1 and 2 sho Department of Health and important: If item 27 is		1 XBurial 2 Cremation 3 Removal from State crematory or oth			Lansdow:	,					
Baltim permit. Pa Departmen Important injury or c				20-2009 March Ea		17 110					
De Ter		Shank males 11	Ol E. North	Avenue B	Balto, MD	21202					
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Multiple Injuries.	ne mode of dying, such as cardiac	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and Death					
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	er	Sequentially list conditions, b									
18	Examine	cause. Enter Underlying Cause (Disease or injury that indicated events resulting in death) Last Due to (or as a consequence of):	-								
and transit	al Ex	d.									
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Division To the Hospital or Attent within 24 hours after death To the Fuueral Director: completely filled in by the	nd place, and due to the										
F % F %	Medical	29b. Signature and title of certifier	29c. License number		29d. Date signed (Monti	h, Day, Year)					
		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		March 14, 2009						
3		Donna M. Vincenti, MD Assistant Medical Examiner 111	Penn Street, Baltimore,	MD 21201							
S Regis	tate	31. Date file (North, Pa 8 2009) 32. Registrar's Signature									
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		For State Registrar		State o	of Mai	ryland /	•	rtment of F tificate of			lental Hy	gien Reg. N	000	9	0.8	469
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Examin		4a. Facility Name (If not inst Canton Manor	tution, giv	e street and nu	ımber)			4b. City, Town, o		of Death			c. County of N/			
Funeral Director		5. Social Security Number 216–36–3096		Sex □ M 2 X] F	7. Age	(In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Unde Hours	er 24 Hrs. Min.	8. Date of B (Month, D April	(Month, Day, Year)			lace (State try) land	or Foreign
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and 2 Health	ı	Martha Kurtz	S	ister-I	n–La			Bayside D		<u> </u>				212		
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To 1 To 1	2	29b. Signature and title of ce	rtifie	2	,	MO		29c. Licens	e626				ate signed (ed (Month, Day, Year)		
7		30. Name and address of pe	rson who	completed cau	se of dea	ath (Item 23	a) (Type, F	Print) 41CKERY	RIDGI	E RM	Coi	VM3/	A M	02	1644	
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Registr		MAR	182	.009 \	ensu	a p	. 4					_				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Yea **Physician** MARY SCOTT MORRISON 0610 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) April 23 1936 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2**X**XF 72 MARYLAND **Director** 219-34-0489 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Modical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 XNo Directo BALTIMORE CATONSVILLE MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 166 WINTERS LANE 21228 Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 XIX Married Saltimore, Maryland 21215-0036 1 □Yes 2 XX No Specify: Specify: BLACK <u>۾</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CASHIER GIANT FOOD 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (ဂ္ FRANK SCOTT NELLIE SMITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Alton Morrison/Husband 166 Winters Lane, Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN CEMETERY 103-20-09 WOODLAWN, MARYLAND 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Approximate Interval Between Onset and Death 23a. Par 1. Em or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho thror heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 20m11 /Medical Due to (r as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to or as a consequence of The law requires that the death certificate be executed use as the burial-transi ding physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) ☐Yes 2 ☐NO o signed by the 9 Unknown ď 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 □ Yes 2 - No-2. 1 ☐ Yes Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∏Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To o After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar

31. Date filed (Month, Day, nP Year 32. Registrar's Signatu MAR 18 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

	1 - For Stata Ragistrar	•	Department of Health and I Certificate of Death	Mental Hygiene Rag. No.	09 08471
Physician	Decedent's Name (First, Middle, Las	Moye	2.0	2. Date of Death Month Day	Year 2009 2110 AM
/Medical Examiner	4a. Facility Name (If not institution, give Charlestown Assis	street and number)	4b. City, Town, or Location of Death Catonsville	h 4c. Cour Balt	nty of Death Limore
Funeral Director	5. Social Security Number 6. Security Number 235 30 2926		htday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 09/23/1925	9. Birthplace (State or Foreign Country) Virginia
ifed at	10a. State 10b. County Maryland Baltin	nore Cate	n or Location onsville		10d. Inside City Limits 1 ☐ Yes 2 🕱 No
ms 23a or 28a-1 show rmust be rotified at nerai Director	10e. Street and Number 709 Maiden Choi	ce Lane RGT 421	10f. Zip Code 21228	_	of What Country?
ar, or ite varine by Fur	11. Marital Status 1 □ Never Married 2 □ Married 3 ⅓ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- to Rican, etc.) 14. R B	lace - American Indian, llack, White, etc. cify: White
than "natur the Medical	15. Decedent's Ed (Specify only highest gra-	ucation de completed) College (1-4or 5+) 1 year	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Office Manager	Green Green	Business/Industry berg ery Store
d off	17. Father's Name (First, Middle, Last)	Sherman H. Castee	e1 Ma	me (First, Middle, Maiden Sum ry Powe11	
of Health and Mer item 27 is marker r other traumatic	19a. Informant's Name/Relationship (7 Carol Vickery /	Daughter 9		Glen Burnie, Ma	aryland 21060
0 == =	20a. Method of Disposition 1 XBurial 2 Cremation 3 1 Donation 5 Other (Specify	Hemoval from State			n-City or Town, State more, Maryland
Department Important: any injury c	21. Signature of Funeral Service Licen	ameracinh	4001 Ritchie High		ervice, P.A. , Mar <u>yland 2122</u>
physician and physician and street burial-transit and physician and street burial-transit and physician and street burial-transit and physician and street burial-transit and physician	Sequentially list conditions, if any, leading to immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of Due to (or as a consequence	of):	n me	Approximate Interval Between Onset and Death
by the attending phy ached for use as the hysician/Medie	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ √0 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		Date of delivery Month Day Year
ate has been signed bage 2 should be det	Parli. Other significant conditions of Coronary A Hyper te. Diabetes	ontributing to death but not resulting in the ry Dise	ase	1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No	b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
is after death. al Director: After this certificat ed in by the funeral director, p. Certification; To Be G.	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Actural 5 Pending investigation 3 Suicide 6 Could not be	(Month, Day Year)	Itpatient 3 DOA Other: 4 Nursing Firme of njury M 1 Yes 2 No	ath (Check only one) Home 5 Residence 6 20 28d. Describe how injury occ 28f. Location (Street and Nu	
rs afte	4 Homicide determined	building, etc. (Specify)	a, death occurred at the time, date and place	City or Town, State)	
within 24 hours and the Funeral IIIed completely filled	(Check only 2 Medical Examone)		d/or investigation, in my opinion, death occi	urred at the time, date and plac	
To To	29b. Signature and title of certifier	Dowlin	My D44372	_	
	30. Name and address of person who Deneen Rowling	completed cause of death (Item 23a)	(Type, Print)	N 1-1	21228

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** JOANNE MICELI 3:00 P. 2009 <u>March</u> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 1014 Craftswood Road Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 10/20/1935 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕮 F Months Days Hours Min. 73 Arkansas 431 60 5734 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, it a Modical Examinational Be notified any injury or other traumatic event, it a Modical Examinational Be notified anone. Baltimore 1 ☐ Yes 2 No Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with innent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or. 21228 U.S.A. 1014 Craftswood Road Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2K No Specify: þ Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Customer Service Oil Company 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold Hannon Juanita Boshers ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Paige / sister 102 Shelly Road Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bavview Crematory 03/16/2009 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** arrthy disease or condition resulting in death) 910196 /Medical Due to (or as a consequence of) **Examiner** b. metabo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed dehydration that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Tropa IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient eral Director: After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) sen, M.D.

State Registrar

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Victoria Steiner - Larsen, in

#18, Baldi

2. Registrar's Sign

old Frederick rd.

31. Date filed (Month, Day, Year)

035527

09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician 9:00p M 2009 March 3. Alexander Mekinski /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Future Care Canton Harbor Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 2 - 26 - 1922 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ☑ M 2 ☐ F Maryland Director 215-12-797 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director N/A Baltimore City MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 445 Drew Street 21224 USA items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White ò Specify. 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+)
N/A is marked other than Elementary/Secondary (0-12) 6 Machine Operator Crown, Cork & Seal 18. Mother's Name (First, Middle, Maiden Surname)

Amelia (unk) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lipiry or other traumatic event ance. Be Stanley Mekinski Amelia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kathryn Mekinski - Daughter 226 Colgate Ave. Baltimore, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Cem. 3-19-09 Dundalk, MD 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 1 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ALZHEIMER'S DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed and burial-tran Due to (or as a consequence of): physician the burial Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. cate has been signed by the page 2 should be detached 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an autopsy performed? 1 Yes 2 No certificate I spital or Attending Physiclan: Theory after death.
Ineral Director: After this certificate y filled in by the funeral director, par 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral Di 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ONE MCRNP 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

ah, senp

31. Date filed (Month, Day, Year)

r. Nill

MAR18 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marked

a2. Registrar's signature

K132808

25 Main St., Ste 200, Revoterstown, MD

		1 _ State	ype or Print in E T DVR, & pe State of Marylan		delible Ink G890 4/2 artment of F rtificate of			2000	001.71.	
Physicia	an	Registrar 1. Decedent's Name (First, Middle, Last)		061	illicate of	Dealli	2. Date of Death	6 ^{Day} 2009 ^{Year}	3. Time of Death 7:10 AM	
/Medic Examin		Henry I. Nygard 4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of Death			Montgomery	
Funeral Director		Montgomery General 5. Social Security Number 6. Sex 18	Hospital 7. Age (In yrs.) M 2□F 93	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day)	9. Birthplace (State or Foreign Country) Mississippi		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is madeal Eval.	Director	Usual Residence of Decedent		r, Town or Lo				g. Citizen of What Co United Sta	10d. Inside City Limits 1 □Yes 2 💆 No untry?	
5-0036 72 hours after death natural", or items 23	d by Funeral		2. Was Decedent Ever in U. Armed Forces? 1 图Yes 2 □ No If Yes, Give Year or Dates: 1942 =		Was Decedent of F	J Jas Decedent of Hispanic Origin? (Specify Yes or No- Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes 2 ☑ No Specify:			ican Indian, , etc. ite	
21215-C d within 72 hr giene. er than "natu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give life. i	dent's Usual Occup kind of work done DO NOT use retire ding Con	during most of work d)	ing	6b. Kind of Business/I Constructi		
Maryland 2 d 2 should be filed th and Mental Hyg 77 is marked other traumatic event,	To Be C	17. Father's Name (First, Middle, Last) Christen Andersen				18. Mother's Nam	e (First, Middle, Ma tockholm	alden Surname)		
e, Mar 1 and 2 sho Health and em 27 is m ther traum		19a. Informant's Name/Relationship (Type Kenneth Nygard/Son 20a. Method of Disposition		39 1	Holland I	or. Chalfo	ont, PA 1	City or Town, State, Z 8914- Oc. Location - City or T		
Baltimore, permit. Pages 1 ar Department of Hee Important: If item any injury or othe		1 ☐ Burial 2 ☑ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	Cl	nesape	sition (Name of matory or other place ake Crema 2. Name and Addre	atory	Mar 18 2009	Beltsville		
Depri June 1000		23a. Part 1. Enter the disease, or complic	MUUSON		933 Gist		er Spring	, Maryland	20910 - Approximate Interval Between	
Physician /Medical Examiner		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	ved	Aat	ic Ar	ewg.	sm	Onset and Death	
I Records, P.O. Box 68760, The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any teaching to the cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequ							
the death certifi	Physician/Medio	IF FEMALE; 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3 [⊒Ectopic pregnanc ⊒Other <i>(specify)</i> _	су		23d. Date of delivery Month Day Year		
Cords, P.O. w requires that the de been signed by the should be detached	ò	Part II. Other significant conditions con	tributing to death but not resu	Ilting in the u	nderlying cause giv	ven in Part I.		cco use contribute to	the cause of death?	
Vital Records, sician: The law requires the certificate has been signe rector, page 2 should be d	Completed	25. Was case referred to medical						prior to c death?	opsy findings available ompletion of cause of 2 □No	
Of VII Physicia this cert al directu	To Be	examiner?	ospital:			ner: 4 Nursing Ho		ce 6 ☐ Other (Spec	rify)	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification on pletely filled in by the funeral director, to the Funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director is the funeral director.	Certification:	1	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury me, farm, str	M 1 □	ry at k? Yes 2 □ No	28d. Describe how 28f. Location (Stre	et and Number or Ru	ral Route Number,	
Ospital or hours after uneral Dire		29a. Certifier 1 Certifying Phys	building, etc. (Specify ician: To the best of my known er: On the basis of examina	wledge, deat	h occurred at the ti	me, date and place,	City or Town,	use(s) and manner as	stated.	
To the H within 24 To the F	Medical	29b. Signature and title of certifier	and manner stated.)	29c. Licens	-		I. Date signed (Month		
		30. Name and address of person who con	mpleted cause of death (Item	23a) (Type,	Print)	nce F	Plailin	Dr. 011	WILLIAM	
Sta Registr	te ar	30. Name and address of person who con HCUM CV CO	VCV(20 32. Registrar's Signal	/ 0 / ()	Kell	VICC /	VIIIP	P1. 000	14/1-10	

State of Maryland / Department of Health and Mental Hygiene

1 - State Registrar

Certificate of Death

2009 2009 08475 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 12, 2009 Physician 11:15 AM Claudia Norris /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Divine Care Abingdon 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Year) Days Months Hours 1 □ M 2 1 F 70 226-46-8854 May 6, Director 1938 Massachusetts Usual Residence of Decedent alth and | enter Head within 72 hours after death with the Maryland alth and | enter Hygiene.

27 is marked other than "natural" or ""
traumatic event the form of 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Bel Air Harford Director 1 ☐ Yes 2 No 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 7129 Talisman Lane 21045 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 □Yes 21□ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo White Specify þ 3 ☐ Widowed ♣ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Management Consultant Government Contracting 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Pages 1 and 2 sho ld be in non to Health and inental Florence Bertha Mackin James Jeremiah Kearns ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 is 1301 Sheridan Place #M Bel Air MD 21015 Andrew Norris/son Department of Health Important: If item 27 any injury or other trong. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State XIX Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Signature of Funeral Service Licensee Ronald S. Wade, Director per 655 W Baltimore St., Baltimore MD 21201 DVR 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Chronic Obstructive Lung Disease vears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the. as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Stroke 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown funeral director, page 2 should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 1 ☐ Yes 2X No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1VIng 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Hospital or Attending 1 🖾 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deatl To the Funeral Director: filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D25205 4pril 20, 200 9 CI

Registrar

State

W.A. Riley, 6565 N. Charles Street, Baltimore, MD 21204

30. Name and address of person who completed cause of ceath (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32. Registar's Signature

9 Denom A. Jacob

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 8:00 P M Torch JUDITH 2009 CHAYES NEIMAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ROLAND PARK PLACE N/A BALTIMORE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month Day, Year) 05/27/1926 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF 349-18-8947 82 TI Director Usual Residence of Decedent 10c. City, Town or Location 10h County 10d, Inside City Limits 28a-f show 1 X Yes 2 □ No notified Director MD BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ral", or items 23a or Examiner must be r 5509 SOUTH BEND ROAD 21209 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 🗓 No Specify: 2 3 ☐ Widowed 4 X Divorced 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If fem 27 is marked other than 's injury or other traumatic event, the Mean one. Elementary/Secondary (0-12) College (1-4or 5+) **EDITOR** HUMANITIES MAGAZINE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHAYES TORCH EDWARD SARAH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5509 SOUTH BEND ROAD, BALTIMORE, MD 21209 JOSHUA NEIMAN / SON 20b. Place of Disposition (Name of Cemetery, crematory or other place)
OHEB SHALOM
MEMORIAL PARK Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 03/17/2009 REISTERSTOWN, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of uneral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Set and Death Inset and Death Immediate Cause (Final disease or condition resulting in death) heart failure Physician quakhe /Medical Due to (or as a consequence of): Examiner Years conditingo chenue if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Years attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760, certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Tes Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred Certification: neral Director: After filled in by the funeral 5 Pending investigation 1 🗌 Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State 31. Date Registrar

onth, Day, Year)

1 AR 1 8 2009

Registrar's Signature

MACGREGIL, B30 W. 40 Th STREET, BALTIMARE, HD 21211

Darch 16, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D13657

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5,20a-c&22 Per FH G889 3/19/09 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 **Physician** March 12, Carmen Daniel Purcell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1018AM 8 Nightengale Way #B7 Lutherville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Yea **Funeral** Days 369-50-7818 56 Director Aug 16, 1952 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location is than "natural", or items 23a or 28a-f show Manch 12,2009 Director MD Baltimore Lutherville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 8 Nightengale Way #B7 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 ☐ Never Married 2 ☐ Married 5-0036 1 □Yes 2X No Specify: White Specify. Completed by 3 ☐ Widowed 4 🎇 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) comen Daniel 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2121 Elementary/Secondary (0-12) 1 2 College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other trainmant. Army helicopter pilot US Army Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carmen D. Purcell Sr Margaret Connors 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Purcell/brother 4490 Patrick Road W. Bloomfield, MI Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State **Bayview Crematory** 4□Donation 5 Mother (Specify) in state 3/19/2009 Baltimore, MD 21. Sign ture Funeral Service Licensee Ronal S Wade Difector 22. Name and Address of Facility Charles L. Stevens Funeral Home 21201 21230 1501 E Fort Ave. Baltimore, MD 23a. Parit. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

a Suicide Selfunflicted GunShot To head Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 ☐ Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 □ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Yes 2□No Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Self inflicted 28c. Injury at Work? After 1 Natural 5 Pending Injury 1018 A Genshot March 12, 2009 1 ☐Yes 2 ☐No tohead investigation 2 Accident within 24 hours after deat To the Funeral Director; 3 Suicide 4 ☐ Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number. City or Town, State) Nighten 4018 204 # B7, Laken IIE, Md 2109 3 Home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6

32. Pegistrar's Signature

M:1:tello

Mr.l.

31. Date filed (Month, Day, Year)

10:18 AMM

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

2 No

3,2009

1 ☐ Yes

Year

1 ☐ Yes 2√∑ No

Michigan

DHMH 17 Rev 1/2001

State Registrar

Trumble Hil

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

30 Per State of Maryland / Department of Health and Mental Hygiene amend #30 Per 1 - State Registrar 08478 Reg. No. 2009 Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** NOI 3 Bobby S. Peek 7 009 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico 4465 Smith Road Salisbury If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Year Hours Davs 1 X M 2 □ F 74 Apr 5, 1934 North Carolina Director 217-28-4287 Usual Residence of Decedent the Maryland 10h County 10c. City, Town or Location 10d Inside City Limits 10a. State th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2√ No Director MD Wicomico Salisbury 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 4465 Smith Road USA 21801 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No altimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2X No Specify þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) painter home improvement 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clyde Peek Henry Geneva Viola Holt ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert Peek/son of Health a item 27 is 405 S. Camden Avenue Fruitland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any injury or otl 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ronal d 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) ned by the a 9 Unknown nis certificate has been signed by director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 We No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 ☐Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. the within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and litt 12/09 450497

State Registrar 100E. Carroll St. Salisbury, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christopher Scott Snyder

31. Date filed (Month, Day, Year)

Amend 20 State of Maryland 7/20/09 TT of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name, (First, Middle, Last) **Physician** 2009 ab Vigren /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Reheb altimere ealth and Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday)
Yrs. **Funeral** Months Days 1 ☐ M 2 💢 F Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Marien Evnu in a must be notified at once. 1 Yes 2 □ No Director MOY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2122 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Şeçondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 150n1 B-2B 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 20a. Method of Disposition 3/25/2009 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) tink. 22. Name and Address of acility OSEPH L. Russ 21. Signature of Funeral Service Licensee Fyneral Home, P. J. Ave. Balto. Md lose 23a. Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failtire. List only one cause on each line. Approximate Interval Between Onset and Death PardioVasc Immediate Cause (Final rero selerotic Physician disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 A No After this certificate has funeral director, page 2 s 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Be Other: 4 1 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To eral Director: After th 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) N Nacan 30. Name and address of person who completed cause of death (Item 23a) (Type Print), AMATUM 501 DC) 2. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR18 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 2009 **Physician** 2:12 PM March Pulant L. nary /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Battmore Washington Medical Center Glen Burnie If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 A F Hours Months Days Director 219-10-3888 3, 1925 Nov. Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b County 28a-f show traumatic event, the Medical Exeminar must be notified at 1 ☐ Yes 24 No Director Maryland Anne Arundel Pasadena 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō Pages 1 and 2 should be filed within 72 hours after death with 23a 38 Brookfield Road 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐Yes 2.1 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 □Yes 2 Ϊ No Specify: þ 3 X Widowed 4 □ Divorced White "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 N/A Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည Howard Triplett Marv Gary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 single beath an Important: If item 27 is lany injury or other trausonce. 38 Brookfield Road Pasadena, Maryland 21122 Kenneth L. Pylant (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/17/09 Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 23a. Part 1. Exper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. McCully-Polyniak Funeral Home, P.A. pproximate Interval Between Onset and Death Immediate Cause (Final 2 week Physician Moseosis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 C Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Falure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No Atria (Fibrillation 24a. Was an autopsy Conq estive 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 115/2009 Jovacce DO068153 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

NOVACLC

31. Date filed (Month, Day, Year)

DC

Hospital

. Glen Burne, MD 21061

State of Maryland / Department of Health and Mental Hygien 2009 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 2:10 PM M uez March /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring Arcola Health & Rehab Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🛱 F Yrs. 95 May 26, 1913 South 212-64-3308 America Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Modical Examiner must be notified at MD MOntgomery 1 ☐ Yes 2√ No Silver Spring Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Pages 1 and 2 should be filed within 72 hours after death with 20902 1135 University Blvd W #407 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: columbian If Yes, Give Year or Dates: Specify white 2 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) minister religion 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Andres Vargas Elvira Sanchez ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trauonce. Hilda Olivia/daughter 1135 University Blvd #209 Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature 1 Fune all rvice Licensee K na d S Walds 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE 4) YOSARDIAL INFARCTION MWLIES Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 2 → NO 3 Probably 4 Unknown 1 □ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 ☐Yes 2 ☑No director, 25. Was case referred to medical examiner? 26. Place of ... th (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

I Director: Af d in by the fur 2 Accident 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and titled certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

MAR 18 2009

ROSENBAUM

31. Date filed (Month, Day, Year)

32. Registrar's Signature

3720

DRAGUT AUF. KENSINGTON, MD

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 3:15 AM ^M Margaret M. Rodefer March 11, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13802 Sand Dune Road Ocean City Worcester If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2 X F 82 Director 220-12-8577 Sept 18, 1926 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD Worcester 1 ☐ Yes 2√2 No Ocean City Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13802 Sand Dune Road 21842 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examines 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. Specify: white 3 N Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 stenographer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilfred Sylvester Rohlfing Catherine Agnes Metzger ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dale Rodefer/son 1540 Robinson Mill Road Darlington, MD 21034 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Nonation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1 Immediate Cause (Final disease or condition resulting in death) Physician ancos /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-trar and Due to (or as a consequence of): attending physician Division or Vital Records, P.O. Box 68760 Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perfe I or Attending Physician: after death. Director: After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes ✓ No 2 ER/Outpatient 3 DOA ို 5 Residence 6 □Other (Specify) 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Sescribe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral DI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of

State

Registrar

31. Date filed (Month, Day, Year

MAR 18 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 9 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 44 7009 Month **Physician** 1045 AM March /Medical Sigrid Rasmussen 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore Northwest Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 KF Months Days Hours Min New York 28, 1919 **Director** 89 Dec. 074-16-5424 Usual Residence of Decedent filed within 72 hours after death with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Evandant must be notified at 1 ☐ Yes 2 XNo Director Baltimore Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6811 Campfield Road Apt. 2 I 21207 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Be Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any linjury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gideon Carlson Sigrid Carlson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7980 Rodman_Court Glen_Burnie, Maryland 21061 <u> Jo-Ann S. Rasmussen - Daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/13/09 Bayview Creatory Baltimore, Maryland 21. Signature of Funeral Societ Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Councer /Medical **Examiner** unknown Sequentially list conditions, it any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed physician and s the burial-transi Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑No Month Day Year 5 Other (specify) P.0. 9 Unknown cate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an 1 □Yes 2 No funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 WOther (Specify) Hospital: 1☐Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 5 Pending investigation 1 WNatural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

Smith Avenue Baltimore MD 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Obbig Bwb 2835

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	otato or many	C	ertificate of	Death		Reg. No.	2009	08485		
	Physici	an	Decedent's Name (First, Middle, Las MARVIN		EYNOLDS			2. Date of De	Day	Year	3. Time of Death		
L.,	/Medic	al	4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Death	March	/13 4c.	L 2009 County of Death	12.30.1		
	Examili	ei	Baltimore-Washington		er	Glen B	urnie			Anne Arui	ndel		
	Funeral Director		405-44-8495	7. Age (III	76 Yrs. last birthda Yrs.	y) If Under 1 Year Months Days		8. Date of Bir (Month, Da November	th 23,1	1932 Sent 1932 Rent	place (State or Foreign ntry) LUCky		
	land ow		Usual Residence of Decedent 10a. State 10b. County		c. City, Town or					1	0d. Inside City Limits		
	e Mary a-f sh iffed	ctor	Maryland Anne A	arundel	Pa	sadena					1 □ Yes 2 X No		
	th with the 23a or 28	Funeral Director	10e. Street and Number 58 Lakeshore Drive			10f. Zip Code 21	122		10g. Citizen of What Country? U.S.A.				
9036	72 hours after death with the Maryland hatural", or items 23a or 28a-f show diest Evantiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates:	in U.S.	8. Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 No	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		14. Race - Americ Black, White, Specify: Whit	etc.		
15-0	"natu	letec	15. Decedent's Edi (Specify only highest grad	ucation de co <i>mpleted)</i>	16a. Decedent's Usual Occupation (Give kind of work done during most of working file_DO_NOT_use retired					nd of Business/In	dustry		
212	withir jiene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Equipment	-/	Wayne Foy & Sons					
land 2	uld be filed fental Hyg rked other tic event,	To Be C	17. Father's Name (First, Middle, Last) Casaus Re	eynolds				ame (First, Middle, Maiden Surname) ra Amelia O'Hara					
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventual be notified at once.		19a. Informant's Name/Relationship (7 Susan L. Berry (1	Type. Print) Daughter)			t and Number or Rui Pasadena, M		er, City or 21122		Code)		
imore			20a. Method of Disposition 1 🛱 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Date -09	20c. Location - City or Town, State Glen Burnie, Maryland								
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licens	see E		McCully-Pol	ess of Facility yniak Funera	1 Home P.	Α.				
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final	plications that caused the one cause on each line.		nter the mode of dy	1	or respiratory a		nd 21122	Approximate Interval Between Onset and Death		
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a co	nsequence of):	Lema	dises regmoni	-					
	Examiner	-	Sequentially list conditions,	b. Due to (or as a	retros) pr	renmoni	745					
×	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		insequence on:								
68760,	rtificate be executed ing physician and s as the burial-transit	al Exa	resulting in death) Last	Due to (or as a co	nsequence of):								
	tificate ig phys as the	Medical		d.									
O. Box	Se di	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	□ Ectopic pregnan □ Other (specify)	су		2	23d. Date of delive Month	ery Day Year		
rds, P.	quires that n signed b uld be deta	þ	Part II. Other significant conditions co	ontributing to death but no	ot resulting in the	underlying cause gi	ven in Part I.			se contribute to the	ne cause of death?		
Division of Vital Records,	The law requires that the death ate has been signed by the atter bage 2 should be detached for u	Completed								24b. Were auto prior to co death? 1 □ Yes	psy findings available mpletion of cause of		
ital	cian: ertifica ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of Deat	1 □ Yes h (Check only o		ILlifes	2/21/10		
of \	Physic this cal dire		1 Yes 2 No	T. 11	2 ER/Outpati	ent 3 DOA				6 ☐ Other (Specif	ý)		
o	Attending Physician: sr death. ector: After this certific. by the funeral director, I	ition	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Ye	ar) 28b. Time Injury	· Wo	rk? □Yes 2□No	28d. Describe I	now injury	y occurred			
Divisi	al or Atter s after dea: I Director d in by the	Certification: To	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (5	At home, farm, s Specify)			28f. Location (: City or Tox		d Number or Rura)	al Route Number,		
× 1	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) Certifying Phy Medical Exam	ysician: To the best of m iner: On the basis of exa and manner stated	amination and/or	ath occurred at the investigation, in my	time, date and place, opinion, death occur	and due to the red at the time,	cause(s) date and	and manner as s place, and due to	stated. o the cause(s)		
	To the within common co	Ž	29b, Signature and title of certifier	mp		29c. Licen	se number		29d. Date	e signed (Month,	Day, Year)		
			30. Name and address of person who co	ompleted cause of death	(Item 23a) (Type	e, Print) Live, We	n burme	· mo	2	1061.	,		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrare	Signature	lad.							

Registrar DHMH 17 Rev 1/2001

entini	State of Maryland / Department of 1-For State Certificate of	Health and Mental Hyg	giene	19 11868			
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)	2	Date of Death	3. Time of Death			
Medical Examiner	Eric Ray Santini		Month Day Year March 7, 2009	1500 hrs			
A	4a. Facility Name (If not institution, give street and number) 995 Jason Court 4	b. City, Town, or Location of Death Gambrills	4c. County of Deat Anne Arundel				
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth (MM/DD/YYYY) 9. Bit	rthplace (State or			
Director	217-11-7250 1X M 2 F 37 Yrs.	Months Days Hours Min.	May 21, 1971	^{gn} West ^{ountry)} Virginia			
è	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	nn .		10d. Inside City Limits			
d d				1 Yes 2 X No			
the Maryland a or 28a-f sh tified at onc	Maryland Anne Arundel Mill 10e. Street and Number	ersville 10f. Zip Code	10g. Citizen of What Cou	intry?			
the M and 2 tiffed tiffed Dire	1108 Indian Landing Road	21108	United St	atos			
fler death with the Maryland 1", or items 23a or 28a-f show any ter must be notified at once. y Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	Decedent of Hispanic Origin? (Specs, specify Cuban, Mexican, Puerto R	cify Yes or No- 14. Race - Amer				
r deat	1 Yes 2 X No						
ins after unally uniner	or Dates:	Yes 2 x No specify: s Usual Occupation (Give kind of wo		hite			
5-0036 ed within 72 hour lygiene "matu nhe Medical Exar Completed		st of working life. DO NOT use retire		, made it y			
0036 within iene. er tha Medic		spatcher	Constru	ction			
21215-0036 uld be filed within 7 Mental Hygies marked other than revent, the Medica To Be Comple	17. Father's Name (First, Middle, Last)		irst, Middle, Maiden Surname)				
212 ould be d Menta s mark ite even	Anthony M. Santini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Wand Address (Street and Number or Ru	la M。 Ray ral Route Number, City or Town, State	e. Zip Code)			
MD dd 2 should be and and and and and and and and and and	Wanda & Anthony Santini/parents 1108 I						
	20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposit crematory or other	ion (Name of cemetery,	Date 20c. Location - City or				
Baltimore, permit. Pages 1 ar Department of Hee Important: If the injury or other fr	4 Donation 5 Other Specify: West Arund	el Crematory 3/10		Maryland			
Salt ermit. Departi mpourt njury	27 Signature of Funeral Service Licensee 22. Na Do:	me and Address of Facility naldson Funeral H	Home & Crematory,	P. A.			
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	II ADDADOIIS KOAC	1 Odenton Marvi	and 21113 Approximate Interval			
/Medical	* failure. List only one cause on each line.		oophatory arrost, shock, or ricart	Between Onset and Death			
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Complications of morb Due to (or as a consequence of):	old obesity	· · · · · · · · · · · · · · · · · · ·	Doun			
<u></u>	Sequentially list conditions, b.						
red A/A/ Bxaminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated c						
E a g 4/	events resulting in death) Last Due to (or as a consequence of):						
cian and ransid dical Ex	X UNPENDED 23a,27,perME, §	3889 3/26/09 TT					
, g 5 E TO	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliver	V.			
lox 68760, leath certificate by a strending physic for use as the bur /sician/Mec	past 12 months:	Il death 3 Ectopic pregnand		Day Year			
Box 68760 death certificate be attending physion of for use as the butysician/Men	1 Yes 2 No 9 Unknown 9 Unknown	er (Specify)					
P.O. Bc	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?			
s, P.C nires that signed I d be deta			1 Yes 2 No 3 Prol	bably 4 🗸 Unknown			
cords law requi			autopsy prior to d	itopsy findings available completion of cause of			
Records, The law require: Grate has been sign, page 2 should be			performed? death? 1 Yes 2 No 1 Yes	es 2 No			
of Vital Records, in Physician: The law requirements of the this certificate has been an oreal director, page 2 should in: To Be Completed.	25. Was case referred to medical examiner?	26.Place of Death (Check on					
Physicer this sral dir	1 ✓ Yes 2 No Inspired 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of Injury		Home 5 Residence 6 Other	r: Scene			
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Division tal or Attendir rs after death. at Director: A led in by the fu	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street	factory, office building, etc. 28	3f. Location (Street and Number or Ru	iral Route Number, City			
Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate to thours after death. Funeral Director: After this certificate has been signed by the attending physicial to the funeral director, page 2 should be detached for use as the buse of the funeral director, page Completed by Physician/Me	4 Homicide determined (Specify)		or Town, State)				
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificatic	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurre (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation						
To the within 2 To the complet	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo				
	() M. //	O.C.M.E.	March 8, 2009	, = -, , . ,			
	30. Name and address of person who completed cause of death (Item 23a)						
Q		Street, Baltimore, MD 2120	01				
State Registrar	31. Date filed (Month, Day, Year) NAR 18 2009 A Registrar's Signature	<i>y</i>					

DHMH 17 Rev 1/2001 OCME 2006

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 2009 Year 5:30 PM M March 15, /Medical Howard Kamber Shapar Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery 4610 Langdrum Lane Chevy Chase 5. Social Security Number If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 11/06/1923 Birthplace (State or Foreign Country)
 MA 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 **■** M 2 □ F Months Hours Director 85 028-12-1620 Usual Residence of Decedent d other than "natural", or items 23a or 28a-f show event, the Mudical Examinations be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Chevy Chase Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 20815-4610 Langdrum Lane filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1943 - 46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married Maryland 21215-0036 \$ 1 ☐ Yes 2 🗷 No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Nuclear Law Elementary/Secondary (0-12) College (1-4or 5+) Attorney is marked other 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) 2 should be find and Mental F Kamber Madeline ျ Oscar Shapar 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If Item 27 P.O. Box 30242 Bethesda, MD 20824-0242 Stephen Shapar/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mar 16 ò permit. Page Department of Important: If any Injury or Bethesda, Maryland 4⊠Donation 5 ☐ Other (Specify) 2009 Uniformed Services Signature of Funeral Service Licensee 22. Name and Address of Facility M00382 Rapp Funeral & Cremation Services Style & Lotheram Silver Spring, Maryland 20910-933 Gist Ave. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) recard /Medical Due to (or 6 a consequence of): Examiner Sequentially list conditions Examiner Disk to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events the death certificate be executed the burial-transit resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown Š requires that signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed aw 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy performed? 1 □ Yes 2 No page The certificate 1 ☐ Yes 2 ☐ No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 □ No 1 🗌 Inpatient Certification: To 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No s after death. the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 9 within 24 hours a the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5530 WISCONSIN AVE 1408, CHEVY CHASE MD M.D. GEORGE W. GRAVES 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** March 15, 2009 2:53 PM Pearl B. Stewart /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Holy Cross Hospital Montgomery Silver Spring | If Under 24 Hrs. | 8. Date of Birth | Hours | Min. | 8. Date of Birth | Month | Day | Year | 1917 If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday)
92 vrs Country) NY **Funeral** Months Days 1 □ M 2 🖾 F 110-07-3187 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Events. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No MD Director Montgomery Rockville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20852-USA 5550 Tuckerman Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No Specify þ Specify: Caucasian 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) County Government Elementary/Secondary (0-12) College (1-4or 5+) 5+ Social Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Blank Gussie Fisher ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dini I. Stewart/Daughter 3812 Lawrence Ave. Kensington, MD 20895-20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Mar 17 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Rapp Funeral & Cremation Services M00382 Stople & Lohi 933 Gist Ave. Silver Spring, Maryland 20910-Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician LYMPHOMA TCELL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ESOPHAGITIS CANDIDA Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or) Examine I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and bein by the tunest director, page 2 should be detached for use as the burlai-fransit all high the funeral director, page 2 should be detached for use as the burlai-fransit CANDIDEMIA resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death

9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 🗓 No 2 XN 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 M Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760. P.O. of Vital Records, Division within 24 hours a

To the Funeral L the Hospita

> State Registrar

29a. Certifier

ADAKU 31. Date filed (Month, Day,

29b. Signature and title of c

30. Name and address of person

ONUKAGU

Medical

DHMH 17 Rev 1/2001

1500 FOREST GLEN RO

and manner stated.

M.D.

who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

SILVER SPRING

09-01949 Thomas Sylveste		Please Ty			nd / Depa	rtmen	t of	Health					egible			9 08	848
	لين	Registrar 1. Decedent's Name (First, Mi	ddio Last\		Cer	tiricate	e or	Death			12	Date of De	Reg. No.			. Time of De	
Physicia Medical Examir		Thomas Sylv		Shock	100							Month March 8,	Day	Year		1322 hrs	
1		4a. Facility Name (if not institu					41	. City, To	wn, or Le	ocation of		TVIGITOTI O,		. County of	Death		
		3995 Perry Hall Roa	ad					Perry F	lali			- 4-	E	Baltimore	Coun	ty	
Funeral		5. Social Security Number	6. Sex	7.	. Age (In yrs. la	st birthda	ay)	If Under	_	If Under		8. Date of E	Birth (MM	(DD/YYYY)	9. Birth Foreign	olace (State o	ÞΓ
Director		220-46-9575	1 X M	2F	6	2	Yrs.	Months	Days	Hours	Min.	Mar 5	5, 19	947	Cour	Mary1	and.
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and and tream		20a. Method of Disposition			20b. F	Place of D	Disposi	ion (Name				Date		Location -			
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Box 68760 e death certificate b the attending physical ed for use as the bu	an/Medical	IF FEMALE: 23b. Was decedent pregnant	in the	23c. If yes, or	utcome of preg		Fot	al death	3	Ectonic	pregnan	cv	23	3d. Date of Month	delivery D	av '	Year
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Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certi	ertification:	3 Suicide 6 X	Could not be	28e. Place	of Injury - At h	ome, farn	n, stree	t, factory,	office bi	uilding, et	c. 2	28f. Location	n (Street n, State)	and Number 3995	er or Rur Perr	y Hall	nber, City L Rd
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		7		(//	9		1						-			

DHMH 17 Rev 1/2001 OCME 2006

Registrar

30. Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D.

State 31. Date filed (Month, Day, Year)

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

March 9, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

per Inf 6889 3/23/09 TT

State of Maryland / Department of Health and Mental Hygiene 0 0 9 1 - For State Registral Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Staten Year John 12:10 AM March 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Cromwell; 8710 Enge Rd. Baltimore Genesis If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**火** M 2□ F 88 Director 215-14-0696 05 20 10 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1XYes 2 ☐ No Baltimore NA MD Direct 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? U.S.A. 21215 3208 Dorchester Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 Is marked other then "neturel', or Itan any injury or other treumatic avent, If a Medical Evaruinat ONCE. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: þ If Yes, Give Year or Dates: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Teacher 12th grade 6vrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mamie John Henry Staten .Iones 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3208 Dorchester Road, Baltimore, Md 21215 Carrie Staten-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State ' 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc 3/18/09 Baltimore, Md 21. Signature of Funeral Service bicensee 22. Name and Address of Facility
March F/H west 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocaydial

Due g (or as a consequence of): Infarction Minutes Cardiomy Years SCHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Artery Due to (or as a consequence of) Year S resulting in death) Last Years Physician/Medical Anemia IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 2 No Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Practitioner NUYSE 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 1c alsi R035894 CRNP March 16, 2009

State Registrar

death with the Maryland

Baltimore, Maryland 21215-0036

item 27 is marked other then "neturel", or items 23a or 28a-f show other traumatic avant, the Medical Evanthal aust be nutilised at

Physician

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

/Medical Examiner

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page 2 has

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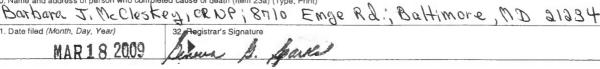
Director:

within 24 hours a To the Funerel (

Hospitel or Attending Physiclen:

31. Date filed (Month, Day, Year) MAR 18 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Catherine Louise Scull Murch 2009 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) April 14 1918 5. Social Security Numb 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 F Months Days Hours 212 70 8912 90 Baltimore, Maryland Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4209 Necker Avenue 21236 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Housewife N/A Housekeeping+Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emma C. Kahl Charles Joseph Schott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne Webster 4209 Necker Avenue Baltimore, Maryland 21236 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Mem. Gdns. March 20 2009 Baltimore, Maryland 22. Name and Address of Facility Lassahn Funeral Home Inc of at re of Funeral Service Licenses 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown neumonia 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1-Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Box 68760, P.0. or Vital Records, Division

the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

show

ral", or items 23a or 28a-f shov Examiner must be notified at

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Important; If item 27 is any injury or other trainonce.

Physician /Medical Examiner

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Pages 1

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filed within 72 hours after death

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

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Examiner

Physician/Medical

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Completed

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3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

or Attending Physician: Certification: After within 24 hours and occur.

To the Funeral Director; Aft To the Hospitai Medical

> State Registrar

6 Could not be determined

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

28f. Location (Street and Number or Rural Route Number, City or Town, State)

e of death (Item 23a) (Type, Print) 30. Name and address of pers

31. Date filed (Month, Day, Year) MAR 18 2009 32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Mary			nt of Health te of Death			giene Reg. No. 2	009	08492
	Physicia		1. Decedent's Name (First, Middle, La VICTORIA SO	st) SNOWSKI					2. Date of Dea Month	Day	2009	3. Time of Death 6:25 A M
	/Medic Examin		4a. Facility Name (If not institution, give	·		4b. City,	Town, or Location		IIMNOII		unty of Death	
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В	Funeral Director		5. Social Security Number 6. S	Sex 7. Age (In □ M 2 10 10	yrs. last birthday) 5 Yrs.	Months	r 1 Year If Under Days Hours	Min.	8. Date of Birt (Month, Da 10/08/	h y, <i>Year)</i> 1903	9. Birthi Coul Mar	place (State or Foreign ntry) y Land
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	r 28a-	Director	10e. Street and Number			10f. Zij	p Code			10g. Citizer	n of What Cour	ntry?
	th with		100 - 12th Aven	ue			21225			U.	S.A.	
36	be filed within 72 hours after death with the Maryland rial Hygiene. Id other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Eventina must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Dece If Yes, spe 1 □Yes	dent of Hispanic Or ecify Cuban, Mexica 2X No Specify		cify Yes or No- Rican, etc.)		Race - Americ Black, White, Decify: Wh	
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alti	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Lice				nd Address of Facili		,		ervice	
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68760,	icate be executed physician and s the burial-transit	dical	•	d								
Box 6	eath certifi attending propertions of the contractions f the contractions of the contr		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p						23d	I. Date of deliv	erv
. Be	Physician: The law requires that the death certiful this certificate has been signed by the attending ral director, page 2 should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown		☐ Ectopic ☐ Other (s	pregnancy specify)				Month	Day Year
P.O.	that the de led by the detached	Phy	9 ☐ Unknown Part II. Other significant conditions of		ot resulting in the u	nderivina	cause given in Part	1	23e. Did to	obacco use	contribute to t	he cause of death?
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o	Phys er this eral dir	ı:To	1 Yes 2 No 27. Manner of Death	1 ☑ Inpatient 28a. Date of Injury	2 ER/Outpatie		OA Strict: 4 N 28c. Injury at Work?	7	ne 5 Resid		Other (Special	fy)
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Division		Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, str Specify)	reet, factor	y, office	2	8f. Location (S City or Tox		lumber or Rura	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b	Medical		hysician: To the best of m miner: On the basis of exa and manner stated.								
3	To the within To the comple	Mec	29b. Signature and title of certifier	and marrier stated.		29	c. License number			29d. Date s	igned (Month,	Day, Year)
			P6:	/ I			RES 001		MARCH 17 2009			
			30. Name and address of person who	completed cause of death					NTROF			
	Sta	to	3001 SOUTH HAI	VOVER STRE			MORE M	0 2	1225			
	Sta Registr		MAR 1 8 2009	auren 1	Signature South							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year MARCH 2:33PM 16 2009 /Medical Facility Name (If not institution, give street and number) 4a. Facility Name (11 1101 111) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Medical ANNE ARUNDEL GLEN BURNIE CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 1 M 2 X F Months Days Hours Director 236-20-5919 88 Sept 10 1920 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 □Yes 2 No Director Maryland Anne Arundel Pasadena 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1590 Wall Drive 21122 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 Mo Specify: 3 ₩Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Naval Academy Accountant of training the state of the st 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Jacob Alby Wyatt Susan Anna Gour 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau 1009 First Street, Glen Burnie, Maryland 21060 James E. Smith 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 03/17/2009 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Bayview Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 23a. P. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between In a diate Cause (Final lease or condition resulting in death) dema elebra **Physician** /Medical Examiner Sequentially list conditions, if any analysis in a list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of and burial-trar Due to (or as a consequence of): physician s the burial Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 **2** No 2 No 1 ☐ Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Baltimore, Maryland 2121

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene.

Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending To the Hospital

> State Registrar

filled in by

completely

Medical

4 ☐ Homicide

(Check only one)

vadim

31. Date filed

29b. Signature and title of certifier

29a. Certifier

DHMH 17 Rev 1/2001

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Type Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

68240

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **SCHOCHET** 1135 AM MAURICE 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day, Year) 08/11/1952 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 213-60-2034 Yrs. 56 CO Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 1 □Yes 2 No MD BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 WICKHAM COURT, UNIT 3 21136 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of workin life. DO NOT use retired) College (1-4or 5+) COMPUTER Elementary/Secondary (0-12) INFORMATION SPECIALIST UNIVERSITY OF MARYLAND 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **SCHOCHET** LOUIS **EDITH** GILDEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELLEN SANDERS / SISTER 2712 APPLESEED RD., FINKSBURG, MD 21048 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State WORKMEN CIRCLE 03/15/2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Somal Cancer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Testrivian au con 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Sopharcal 1 ☐ Yes 2 No 1 □ Yes 2 No 25. Was case referred medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner Examiner The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

show

the

Director

Funeral

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Completed

Be

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?7 is marked other than "natural", or items 23a or 28a-f st traumatic event, it is Medical Experient must be notified

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Experimentons.

Baltimore, Maryland 21215-0036

sician and burial-transit attending physician for use as the buria signed by the a page 2 should has

certificate : After this certifica e funeral director, p

Physician/Medical ⋧ Completed Be Certification: To

Medical

2 Accident

3 Suicide

29a. Certifier

4 Homicide

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu To the Hospital or within 24 hours a To the Funeral D

> State Registrar

29b. Signature and title of certifier

6 ☐ Could not be

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Aronue Sule 203 Baltimore MD 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

and manner stated

31. Date filed (Month, Day, Year) 2. Registrar's Sign

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Anna M. Travers 2009 9:24 March 16 Α. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Villa Nursing Home Baltimore Catonsville Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours Days 1 □ M 2 🗓 F 220 12 0498 83 08/05/1925 Maryland Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 7 is marked other than "natural", or items 23a or 28a-f shoi traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2X No Catonsville Director Baltimore |Marvland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21228 U.S.A. 711 Academy Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2**X** No Specify: Specify: ξ White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 8th College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Trice Clara Williamson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is:
any Injury or other trau Baltimore, Maryland 21230 3102 Ottawa Avenue Mildren Robinson / Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/20/2009 Baltimore, Maryland Cedar Hill Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 terome 23a. Fert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ORPBIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine he law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Vear Day in the past 12 months? 1 ☐ Yes 2 🔼 No 5 Other (specify) signed by the a d be detached for P.O. I 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🏂 Unknown ficare has been się r, p∈ge 2 shoufd b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No certificale or Attending Physician; funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation nours after death, neral Director; Aft y filled in by the fun 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, 31. Date filed (Month, Day, Year) State

Registrar

₽ 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		٠	For State Registrar		aryland / Dep <i>Ce</i>	ertificate of		d Mental Hy	giene Reg. No. 2	09 08496	5
	Physicia /Medic		1. Decedent's Name (First, Mid Hczekiah	Thompson				2. Date of De Month 03	Day	Year 1702 M	
	Examin	er	4a. Facility Name (If not institute BALLMOR & V 5. Social Security Number	A Medica	Lenter ge (In yrs. last birthda)	BAL	or Location of De HMO Re r I If Under 24 H			y of Death N/A 9. Birthplace (State or Foreign	7
	Funeral Director		219-66-9336 Usual Residence of Decedent	1 XM 2□ F	49 Yrs.	Months Day		in. (Month, Da	ay, Year) -1959	Country) MARYLAND	_
	aryland show		10a. State 10b. Count	у	10c. City, Town or l	ocation				10d. Inside City Limits	Τ
	e Mar Ba-f s	Director	MD. N/	A:	BALTI	10RE				1 XYes 2 No	
	th with the Marylar 23a or 28a-f show		10e. Street and Number 2900 RIDGEW	OOD AVE.		10f. Zip Code 212			10g. Citizen of V	,	
336	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Modical Examinar must by notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Ma 3 □ Widowed 4 ☒ Divorce	If Vac Giva	Ever in U.S. 13 No	. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☐ N		(Specify Yes or No erto Rican, etc.)		ce - American Indian, ck, White, etc. ^{fy:} BLACK	
15-0	hin 72 hours e. an "natural"; M.chral Exc	Completed	(Specify only high	ent's Education lest grade completed)	(Giv	edent's Usual Occ e kind of work don DO NOT use retii	upation e during most of w	vorking		susiness/Industry	
212	d with giene.	шo	Elementary/Secondary (0-12)	College (1-4or 9	5+)	RIVER	/		TRUCKI	(NG	
Maryland 21215-0036	s 1 and 2 should be filed if Health and Mental Hygin Item 27 Is marked other other traumatic event, II	To Be C	17. Father's Name (First, Middle JOHN JOHNSO)					tame (First, Middle FRANCES		,	
ary	2 should and N ls mail		19a. Informant's Name/Relation	nship (Type. Print)	19b. Mai	ling Address (Stre	et and Number or	Rural Route Numb	er, City or Town,	, State, Zip Code)	_
	s 1 and 2 of Health a Item 27 Is other trai			MILLARD (MOTH				BALTIMOR	E, MARYI	AND 21215	
Baltimore,	9 0 - =		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	(Specify)		FOREST V	ETERANS	3-20-200		- City or Town, State MILLS, MARYLA	NI
Balt	permit. Page Department Important: I any Injury o once.		21. Signature di Funeral Service	eLicens eJONAZHAN	/ ^	2. Name and Add		HILLIPS I		SERVICE MARYLAND 21217	
	Physician		23a. Part 1 Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	st only one cause on each li	d the death. Do not e	nter the mode of d	ying, such as card	liac or respiratory a		Approximate Interval Between Onset and Death	
٦	/Medical Examiner			b	a consequence of):						
Mp	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	5 c	a consequence of):						
,09289	ificate be executed g physician and as the burial-transit	edical E)	rosulting in death) Last								
O. Box 6	attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death 3	☐ Ectopic pregna ☐ Other (specify)	ncy			ate of delivery onth Day Year	
ds, P.O.	ires that the di signed by the		Part II. Other significant condi	tions contributing to death b	out not resulting in the	underlying cause g	iven in Part I.			tribute to the cause of death?	_
Sor	law requires as been sign 2 should be	etec			-,,.			_			_
Division of Vital Records,	i clan: The lav certificate has ector, page 2	Completed by			-				osy ormed?	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No	
Z.	siciar certil	Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☑ No	Hospital:			thor:	eath (Check only o			_
of	g Physer this eral dir	n: To	27. Manner of Death	28a. Date of Inju	ury 28b. Time	ent 3 🗆 DOA	4 LJ Nursing	Home 5 Resi	dence 6 Oth		_
<u>io</u>	ttending F death. ctor: After / the funera	atio	1 Natural 5 ☐ Pend 2 ☐ Accident inves	ing (Month, Da tigation	i <i>y, Y</i> ea <i>r)</i> Injury		ork? ⊒Yes 2.⊒No		,,,		
Divis	al or Atte s after des il Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 28e. Place of Inj	ury - At home, farm, s c. (Specify)	treet, factory, office)	28f. Location (: City or Tox	Street and Numb wn, State)	ber or Rural Route Number,	
	To the Hospital or Attending Physician: within 2 hours after death and To the Funeral Director: After this certific completely filled in by the funeral director,	edical C	29a. Certifier 1 Certify (Check only one) 2 Medica	ring Physician: To the best al Examiner: On the basis of and manner st	of examination and/or	ath occurred at the investigation, in my	time, date and pla opinion, death oc	ace, and due to the ocurred at the time,	cause(s) and madate and place,	anner as stated. and due to the cause(s)	
	To the vithing to the company of the	Me	29b. Signature and title of certif			29c. Lice	se number		29d. Date signer	ed (Month, Day, Year)	
	114		30. Name and address of person Kimburly Boswc	n who completed cause of c	death (Item 23a) (Type	Print)	StR00+	Raltina	eo MIN	2/20/	
	Sta	te ar	31. Date filed (Month, Pay, Yea AR 18 200	9 General 32. Registr	ar Signature	1		11110	<u> </u>	//	

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State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Marylar		epartment of H Certificate of L			-	giene Reg. N	009	08497	
П	Physicia	an	1. Decedent's Name (First, Middle, Last,	ilentine				1	2. Date of De Month	ath Day	Year		
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or			0 3		2009 County of De	\	
-	Funeral	щ	University of M 5. Social Security Number 6. Sec	aryland 7. Age (In yrs.	last birth	Baltimo	ore;		8. Date of Bir (Month, Da	th	9. B	irthplace (State or Foreign	
	Director		215.22.0809	M 2√√3√F 81	Yı	Months Davs	Hours	Min.	(Month, Da		(Country) MD	
	yland how		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town o	or Location						10d. Inside City Limits	
	he Mar 28a-f s	Director	MD ANNE ARUN 10e. Street and Number	DEL	CL	EN BURNIE				10a Citiz	en of What C	1 ☐ Yes 2XX No	
	h with 23a or	al Dir	549 CRESTPARK DR.			21061	I			rog. Onz	USA	ountry:	
	items	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S.	13. Was Decedent of Hi If Yes, specify Cuba	ispanic Ori ın, Mexicar	igin? (Spec n, Puerto R	ify Yes or No ican, etc.)	- 1	4. Race - An Black, Wh	nerican Indian, ite, etc.	
903	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Expirither is ust be notified at	þ	1 ☐ Never Married 3 ☐ Widowed 4 ☐ Divorced	1 XXes 2 No If Yes, Give Year or Dates:	-46	1 □Yes 2√√No	Specify:	ecify:			Specify: WHITE		
15-(in 72 h n "natu Mudical	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	16a. D	Decedent's Usual Occupa Give kind of work done of ife. DO NOT use retired	upation e during most of working ed)			16b. Kind of Business/Industry		s/Industry	
212	filed within Hygiene. other than '		Elementary/Secondary (0-12)	College (1-4or 5+)		BOOKKEEPING			(5)			INDUSTRY	
land	s should be filed within and Mental Hygiene. is marked other than aumatic event, the man	To Be	17. Father's Name (First, Middle, Last) HERMAN LOTTERER						<i>(First, Middle,</i> .INTHICU		surname)		
Ë	(4 = 12		19a. Informant's Name/Relationship (Ty	pe. Print)	19b. N	Mailing Address (Street a					Town, State,	Zip Code)	
re, l	s 1 and of Health item 27 other t		ROBERT G. VALENTINE 20a. Method of Disposition	HUSBAND 20b. I	545 Place of D	O CRESTPARK DR Disposition (Name of crematory or other place	C., CLE	EN BURN Da	HE, MD	21061 20c. Loc	ation - City o	r Town, State	
Baltimore,	: Page tment c tant: If jury or		1 ☑ Surial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	CR0		LLE VET. CEM.	Į M		, 2009	CR	OWNSVIL	LE, MD	
Bal	permit. Pages 1 and Department of Heali Important: If item 2 any Injury or other once.		21. Sign, Tré et Funeral Service Licens K. CREGORY	FINK MOTT	48	22 Name and Addres FINK FUNERAL 426 CRAIN HW	ss of Facilit HOME, Y.S.,	P.A. GLEN	BURNIE,	MD 21	061		
			23a. Part 1. Enter the disease, of compl shock, or heart failure. List only of	cations that caused the dear	th. Do no							Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate C se (Final disease or con filon resulting in death)	Due to (or as a consec	_	hemorra	ge						
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68760,	tificate be executed g physician and as the burial-transit	al Ex	resulting in death) Last	Due to (or as a consec	uence of)	:							
189		Medical	IF FEMALE:										
Вох	death certi	by Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of	al death	3 Ectopic pregnancy	/			23	3d. Date of d Month	elivery Day Year	
P.O.	at the o	Phys	9 Unknown	9 Unknown			:- D I		220 Did t		a contributo	to the cause of death?	
rds,	quires then signe and be d	d by	Part II. Other significant conditions con	nubuling to death but not res	ulung in u	ne underlying cause give	en in Fart i		1 🗆 '			Probably 4 Unknown	
ора	law rec nas bee 2 shou	Completed							24a. Was			autopsy findings available ocompletion of cause of	
E H	in: The ificate l		25. Was case referred to medical				00 Bi	(D 1)	perfo 1 □ Yes	rmed? 2 No	death? 1 □ Ye		
Ţ	nysicia nis cert direct	lo Be	examiner?	lospital: 1 Inpatient 2] ER/Outp	atient 3 DOA Othe	or.		<i>(Check only o</i> e 5 ☐ Resi		☐Other (Sp	ecify)	
o uo	ding Pl h. After t funeral	tion:	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Tir Inji	ıry Work	yat ?? Yes 2□		d. Describe I	now injury	occurred		
Division of Vital Records,	ir Atten ter deat irector: irector:	Certification: To	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	l ome, farm fy)				If. Location (S City or To	Street and vn, State)	Number or f	Rural Route Number,	
Ω	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a		29a. Certifier Certifying Phy	sician: To the best of my kno	owledge,	death occurred et the tin	ne, date ar	nd place, a	nd due to the	cause(s)	and manner	as stated.	
	the Ho hin 24 I the Fu npletely	Medical	(Check only 2 Medical Exami one)	ner: On the basis of examination and manner stated.	ation and/	or investigation, in my op	pinion, dea	ath occurre	d at the time,	date and p	olace, and du	ue to the cause(s)	
.	wit v	<	29b. Signature and title of certifier	500 MD		Au41		SV18		211	signed (Mor	nth, Day, Year)	
			30. Name and address of person who co	impleted cause of death (Iter	n 23a) (T					'n	71-0	,	
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signal	ature	ball	124	1/7/m	re, 11		01201	,	
	Registr		MAR 1 8 200	Q / Days	19 1	Marke							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month WALKER **Physician** ONAL MARCH 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SECOURS BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth

Month, Day 9./Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** 1 M 2 □ F Months 216-88-9150 Usual Residence of Decedent **Director** filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f shor aumatic event, the Modical Examiner must be notified at 1 Yes 2 □ No Director More 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🕅 No Specify. ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injuy or other traumatic event one. 17. Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship (Type. Print) mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) eagu 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 💢 Burial 2 □ Cremation 3 □ Removal from State 200 4 Donation 5 Dother (Specify) arme 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Avo 23a. Part / Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediale Cause (Final disease or condition resulting in death)

Due to (or as a consequence of): Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 1 ☐ Yes certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 100 2 □No 1 □Yes 1 ☐Yes 25. Was case referred to edical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Impatient 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 Pending after death.

I Director: Af 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral I

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State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death

29b. Signature and title of certifier

051

Registrar's Signatur

tem 23a) (Type, Print)

0030355

BON SECOURS

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G890, 4/30/09, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2009 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 4, 2009 arch /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs last birthday) Security Number 9. Birthplace (State or Foreign Mountry) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days Hours Min 1 M 2 □ F う Months Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination must be a cilled at Director 1 XYes 2 ☐ No MOCE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) rrivate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be iams ပ -Velyn urus 19a. Informant's Name/Relationship (Type. Print) 1ster 19b. Mailing Address (Street and Number or all Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 🛱 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) torest Son 22. Name and Address of Facility

JOSEPH L RUSS Fun

22.2 W. North Ave. 21. Signature of Funeral Service Licensee Home uneral e. Bal 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart trillure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** race liver ILMRVI /Medical Due to (or as a consequence of): **Examiner** Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed burial-transi and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 ☐No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) to the runeral birector; After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performed? 1 □ Yes 2 💢 No 24b. Were autopsy findings available prior to completion of cause of death? insufficiency Kenai 1 □ Yes_ 2 🗆 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{XOther} \(\text{(Specify)} \) \(\text{FOCC} \) examiner? 1 ∐ Yes 2 **2** No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural
2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0035+12 allarine 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Surkan ST. HUSPICE beeph HAIZIUSON Kicheri 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

3/14/09 8:50Am

Quetis Williams

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08500 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ^{Day} 2009 Thomas D. White March 3, 7:00 AM M /Medical 4a. Facilify Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8804 Walther Blvd #3413 Baltimore Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1 M 2 □ F 217-22-3522 80 Director Feb 2, 1929 Maryland Usual Residence of Decedent within 72 hours after death with the Maryland Show 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, The Michigal Examinating must be a wither at 10d. Inside City Limits MD Director Baltimore Baltimore 1 ☐ Yes 2√∑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8804 Walther Blvd #3413 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: *51-53 þ 1 ☐ Yes 21 No Specify: White 3 N Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) mechanic diese1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andrew Thomas White Anna Cecilia Welsh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Mink/daughter 15 Hidden Valley Drive Newark, DE 19711 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 XDonation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licenses Ronal C S Wade, State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Pa 1. Enter the discase, or or mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final **Physician** disease or condition resulting in death) alianont /Medical Due to (or as a complequence of): **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and I-transit physician a the burial-1 Due to (or as a consequence of): Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Year Day 5 ☐ Other (specify) 4 Pregnant at time of death ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown as been signed 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed funeral director, page certificate 1∐Yes 2. Wo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Thomas White " 3/3/04 at Division of Vital Records, P.O. Box 68760 or Attending Physician:

Baltimore, Maryland 21215-0036

within 24 hours after death To the Funeral Director; filled in by the Hospital completely

Registrar

31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)